Proceedings of
The Eleventh Annual Conference-1991

HEALTH OF THE YOUTH AND THE FEMALE CHILD

April 18-20, 1991

Venue :
Madras School of Social Work, Madras

Edited by :
Dr. Ashok Sahni
Professor and Hony. Executive Director

INDIAN SOCIETY OF HEALTH ADMINISTRATORS
104 (15/37), CAMBRIDGE ROAD CROSS, ULSOOR, BANGALORE-560 008
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Preface

In keeping with the mandate of the Constitution of India, the Government of India has evolved a National Health Policy which provides for a comprehensive and integrated approach to health and development of Indian citizens. The emphasis of the Health Policy is on preventive, promotive, and rahabilitative aspects of health care, particularly directing that attention and resources be focussed on the vulnerable or high risk groups.

During the last four decades, since Independence, in view of the overwhelming problems of rural health, the emphasis of the Government of India has been on developing rural health infrastructure, and implementing the public health programmes against common communicable and non-communicable diseases. With the emergence of the concept of risk approach to health care in the early 1980s, and in view of the very obviously high risk groups, namely, mothers and children, the nutrition, MCH and family welfare programmes have been admirably geared up in India in the last one decade.

The national and international successful experiences of improving the national health status within the existing resource constraints, has considerably encouraged the identification and targetting of high health risk groups in health policies and programmes. Thus, risk groups in the population are being progressively identified and risks studied, so that appropriate policies and programmes could be launched or strengthened to improve their health.

Within the well-recognised risk group, viz., the children, the female child, particularly in the Asian countries, has been recognized to be at relatively higher risk of suffering ill- health and mortality, compared with the male children, for several reasons. In order to focus world-wide attention on this group, the WHO had declared 1990 as the Year of the Female Child. To spread professional awareness about issues relating to the girl child in the SAARC countries, SAARC declared the decade 1991-2000 as the Decade of the Female Child.

In India, the female child population (below 15 years of age) which was 132.38 million in 1981 increased to 162 millon by early

1991 and would increase to 192 million by 2001. Approximately 12 million girls are born in India each year. They are faced with the challenge of survival and growth. The female child compared to the male child has 33% to 50% greater risk of death. And, the female child, in spite of our reverence of "a woman as a mother", is socially, economically, and psychologically humiliated and exploited. Further, even in the event of survival, the consequences of female child marginalization, in terms of her future maternal role, maternal risk and even stunting of the next generation, are grave, which warrant a nation-wide systematic approach to the problem.

An emerging high health risk group, not often recognised as such, is the youth. Approximately 20.6% of the total population of 846 million in the country consists of youth (between 15-34 years as per WHO definition). In 1981, the youth population was approximately 125 million. It increased to about 174 million by early 1991 and would increase to 198 million by 2001.

Keeping in view the important role which the youth can play towards national development, as well as the emerging health problems of the youth, WHO declared 1985 as the International Youth Year. In the last few years due to socio-economic and political factors, there have been increasing health problems in the youth-unemployment, suicide, alcoholism, sex related offences, venereal disease and now AIDS, and general adjustment problems in the youth. Today, the youth in India form one of the most vulnerable groups, who on the one hand are expected to be the leaders to determine the destiny of India, and on the other hand are an exploited and confused group.

ISHA with its commitment to the health and development of the Indian citizens, and particularly the vulnerable groups, had organized several of its Annual Conferences on the themes of the high risk population sub-groups. In 1987, the theme of ISHA's Eighth Annual Conference was "Health of the High Risk Groups - Mothers, Children and Elderly". Keeping in view the intimate relationship between MCH and development, in 1988, the theme of the Ninth Annual Conference was "Health of Women and Children for Development". Keeping in view the higher vulnerability of these sub-groups living in the villages and urban slums, the theme of the ISHA Conference in 1989-90 was, "Health Care for the Villages and Urban Slums". In view of the rising national concern with female child issues, and the emerging risk group of the youth, the Indian

Society of Health Administrators, chose the theme of the Eleventh Annual Conference in 1991 as 'Health of the Youth and the Female Child'.

The Conference was inaugurated by His Excellency Shri Bhishma Narayan Singh, Governor of Tamil Nadu. Dr (Mrs) Lalitha Kameswaran, Vice Chancellor, Dr M G R Medical University and Chairperson of the Organizing Committee, presided at the inauguration. Keynote addresses were delivered by Dr(Mrs) Jaya Kothai Pillai, Vice Chancellor, Mother Theresa Women's University; Dr T C Mohan, Vice Chancellor, Annamalai University; Dr Banoo J Coyaji, President, King Edward Memorial Hospital, Pune; Smt Sarojini Varadappan, Chairperson of the Indian Red Cross Society, and Dr Ashok Sahni. The Conference was attended by about 200 delegates consisting of professionals and administrators from government departments, health and medical training and research institutions, voluntary organizations, health professionals, social welfare personnel, post-graduate students, and youth delegates.

On behalf of the Governing Body and General Body, grateful thanks are expressed to the Organizing Committee for organizing very successfully the Conference and mobilizing the resources, as well as, mobilizing large nurnber of interested, active participants. I am particularly grateful for the inspiring leadership of Dr(Mrs) Lalitha Kameswaran, Chairperson of the Conference, and Vice Chancellor, Dr M G R Medical University, Tamil Nadu, to Dr E S Rahavendra, Chairman of the Finance Committee of the Conference and Director, DANIDA Project, Tamil Nadu, Dr P Krishna Murthy, Chairman of the Scientific Committee and Director, Gandhigram Institute of Rural Health, Dr M Swaminathan, Chairman of the Souvenir Committee and Health Officer of Madras City Corporation, Mr T Jayaraj Devadas, Chairman of Reception Committee and Regional Secretary of German Leprosy Relief Association, Dr Sumathy S Rao and Mr C Nagendra of the Hospitalities Committee for their organizing assistance. I am also grateful to Dr(Mrs) Hyma Balachandran, Organizing Secretary of the Conference and Project Coordinator IPP-V, Government of Tamil Nadu, and Mr Pius Kalathil, Conference Treasurer and Administrator, Gremaltes Referral Hospital, Madras, both of whom worked hard behind the scenes, to make the Conference a success as well as a pleasant experience for the participants.

We are grateful to the Indian Public Health Association 34th All India Conference; Dr M G R Medical University, Tamil Nadu National Pharma, Thanjavur; Pharm Products Private Ltd; Tamil Nadu, Dadha Pharmaceuticals Ltd; and DANIDA Project, Tamil Nadu, for co-sponsoring the Conference. We are also grateful to the Departmet of Science and Technology, Ministry of Science and Technology, Government of India, for financial contributions towards partial printing cost of the Summary Report and this publication.

Indian Society of Health Administrators hopes that this publication will draw the attention of the planners and leaders to the urgent psycho-socio-physical health and developmental needs of the youth.

ISHA hopes that leaders, administrators and professionals, at whatever level they are operating-National, State, District or local levels, and even in their role as parents of youth and female children, will reflect upon the suggestions and recommendations, and will seize upon whatever opportunities for action are available at their level, to improve the health of the youth and the female child, even within the existing resource constraints. ISHA also hopes that this book will pave the way for a national commitment to focus policies, programmes and resources towards promoting healthy development of the youth and the female child in India.

Dr Ashok Sahni
Professor and
Hony Executive Director

1991

Summary ,Conclusions and Recommendations

I. Need for the Conference

The Government of India has evolved a National Health Policy which lays stress on the preventive, promotive and rehabilitative aspects of health care. The policy provides a comprehensive and integrated approach towards health and development of Indian citizens. The goals of health and development are emphasized in the Constitution of India. This development is to be achieved through elimination of poverty, ignorance and ill-health, by raising the level of nutrition and the standard of living of the people, the improvement of public health, so as to improve the health and strength of the men, women, youth and children, and opportunities to develop in a healthy manner.

Approximately 20.6% of the total population of 846 million in the country consists of youth (between 15-24 years as per WHO definition). In 1981, the youth population was approximately 125 million. It is likely to be about 171 million by the beginning of 1991 and 198 million by the beginning of 2001. Keeping in view the important role which the youth can play towards national development as well as the emerging health problems of the youth, WHO declared 1985 as the International Youth Year. In the last few years, due to socioeconomic and political factors, there has been increasing health problems in the youth - unemployment, suicide, alcoholism, sex related offences and general adjustment problems in the youth. Today, the youth in India form one of the most vulnerable groups, who on the one hand are expected to be the leaders to determine the destiny of India, and on the other hand are an exploited and confused group.

Another vulnerable group is the female child in India. The female child population in India (below 15 years of age) which was 132.38 million in 1981 will increase to 162 million early 1991 and 192 million by 2001. Approximately 12 million girls are born in India each year. They are faced with the challenge of survival and growth. The female child compared to the male child has 33% to 50% greater risk of death. And, the female child, in spite of our reverence of "a woman as a mother", is socially, economically and psychologically humiliated and exploited.

The Indian Society of Health Administrators is committed to health and development of its citizens, particularly vulnerable groups. The theme of its Eighth Annual Conference in 1987 was "Health of the High Risk Groups: Mothers, Children and Elderly". In view of the specific importance of health of mothers, the theme of the Ninth Annual Conference in 1988 was "Health of Women and Children for Development". Since majority of these vulnerable groups - mothers, children and elderly live in rural areas and urban slums, the theme of the Tenth Annual Conference in 1990 was "Health Care for the Villages and Urban Slums". In keeping with its commitment to the cause of vulnerable groups, the Indian Society of Health Administrators has chosen for its Eleventh Annual Conference the theme, "Health of the Youth and the Female Child".

II. Objectives of the Conference.

The Objectives of the Conference were:

a. To create an awareness among the professionals, administrators, and the public regarding health issues and problems of youth and the female child.

b. To review the actions and programmes for health and development of the youth and the female child by the governmental and non-governmental agencies.

c. To recommend changes in polices, programmes and resources for psycho-social and health development of the youth and the female child.

III.Content of the Conference

The Conference focussed on the following issues of the Conference theme:

a. Health and Medical Aspects of the Female Child.

b. Psycho-social and Management Aspects of Health of the Female Child.

c. Health and Medical Aspects of Youth.

d. Psychosocial Aspects, Education and Employment, Mental Health Promotion and Management Aspects of the Youth Health.

IV.Conference Methodology

The Conference was inaugurated by His Excellency Shri Bhishma Narayan Singh, the Governor of Tamil Nadu. The Conference was presided over by Dr(Smt) Lalitha Kameswaran, Chairperson of the Organizing Committee of the Conference, and Vice Chancellor, Dr M G R Medical University, Tamil Nadu; Dr E S Rahavendra, Director of DANIDA Project, Tamil Nadu and Chairman of the Conference Reception Committee, welcomed the Chief Guest and delegates. Dr Ashok Sahni, Hony Executive Director of ISHA gave a brief introduction of the Society. Smt C K Gariyali, Special Secretary, Health, Government of Tamil Nadu presented a momento to the

Chief Guest and released the Souvenir. Dr(Mrs) Hyma Balachandran, Organizing Secretary of the Conference and Project Coordinator - IPP-V, proposed the vote of thanks.

Keeping in view the objectives of the Conference, the plenary session of keynote addresses, seven scientific sessions, and one panel session were held. Keynote addresses were also presented on each of the subthemes of the Conference in the respective scientific sessions.

The keynote addresses were delivered by Dr(Smt) Jaya Kothai Pillai, Vice Chancellor, Mother Theresa Women's University, Dr T C Mohan, Vice Chancellor, Annamalai University, Dr Banoo J Coyaji, President,King Edward Memorial Hospital, Pune, Smt Sarojini Varadappan, Chairperson of the Indian Red Cross Society and Dr Ashok Sahni. The Conference was attended by about 200 delegates consisting of professionals and administrators from government departments, health and medical training and research institutions, voluntary organizations, health professionals, social welfare personnel, post-graduate students, and youth delegates.

V.Ex hibition on Health of the Female Child

As part of the Conference, an exhibition on health of the female child was organized by the Department of Public Health, Government of Tamil Nadu in close collaboration with the Municipal Corporation, City of Madras and IPP-V, Information, Education and Communication Division. The exhibition was also inaugurated by His Excellency Shri Bhishma Narayan Singh, the Governor of Tamil Nadu. It was well attended.

VI.Summary and Conclusions

A : Health of the Female Child

Female child demography - morbidity and mortality

1. The Conference noted with concern, the continuing decline in the sex ratio even in the 1991 Census. This has belied hopes of an improved female child situation with development . The de clining sex ratio since 1901 now stands at 929 females/1000 males. Whereas in developed countries it tends to be 1030-1040 females per thousand males.

2. The Conference noted that mortality in females was higher than males at all ages, and more marked in under-five children. The causes of higher female child mortality were, comparatively poorer nutritional status of female children; higher morbidity, particularly respiratory diseases and riboflavin deficiency; poorer access to health services as compared with male children; neglect during illness. Studies showed that prevalence of kwashiorkar in females was three to five times more than males, but hospitalization of boys for kwashiorkar outnumbered females by 50 to one.

Recent developments influencing demographic sex differentials

3. The Conference also noted that two recent developments have significant implications for female child demography in India. One unfavourable for female child development and the other favourable to the female child. The unfavourable development related to the technological advance of sex detection techniques, namely amniocentesis, chorion villus biopsy and ultrasound. Its potential to influence female child demography can be assessed from the estimate of one third of the expected annual female births in Bombay being aborted every year since 1984 with these techniques. These practices have become widely popular in cities and large towns especially in Northern and Central India, and rapidly becoming popular in Southern India too.

The second significant recent development is the rapid expansion of the ICDS scheme. Indepth studies have shown reduction of male female mortality differentials, (and possibly reduction of school enrollment differentials) in the ICDS areas. Overall the ICDS programme had a favourable impact on female child survival.

4. The Conference noted with concern, the continuing practice of female infanticide in large parts of the country, and specifi cally highlighted female infanticide in Rajasthan and two dis tricts of Tamil Nadu (Madurai and Salem). The successful role of voluntary local pressure groups in Usilampatti of Madurai dis trict was highlighted.

Girl child's education and skills development

5. The Conference observed that the female child, having survived infancy and early childhood, continued to suffer discrimination in terms of educational opportunity and skills development. Thus, there was a school dropout rate of 55% at primary school level and 77% at higher primary level. This led to serious handicap in subsequent life. In fact in 100 districts of the country, the female literacy rate was 5-7%. Low literacy led to early marriage, high fertility, less chances of having antenatal care, and, poor quality of child care and self care in the maternal role.

Reproductive health indicators

6. The Conference noted that problems of reproductive health faced the girl child as she grew up. Low age of marriage continue, especially in backward districts of all States, urban slums (e.g. Madras); and particularly in the four States of Rajasthan, Bihar, Madhya Pradesh and Uttar Pradesh, which had more than 60% of its female population below 19, already married. The Conference noted that teenaged mothers faced high maternal risk for the rest of their reproductive life and tended to gave birth to high risk babies.

7. The Conference noted that early age at marriage has serious demographic consequences. The States with more than 60% women married before 19, also have highest average total fertility (5.2 - 5.8 Children per woman), whereas States with less proportion married before 19, show low fertility. Similar was the influence of female illiteracy.

8. The Conference noted that prostitution of minor girls was on the rise. About 20% of the estimated two million prostitutes in India are minors.

Female child labour

9. The Conference observed the preponderance of female child labour in low skilled industries (such as beedi industry) and low skilled jobs in cottage industries (e.g. match industry and gem polishing). Such employment leads to stunting of mental growth due to work monotony at an early age. In some industries, the girls faced a risk of pelvic deformity due to prolonged, cramped sitting in the growing age.

10. The Conference observed that several legislations exist for female child protection. However, for effectiveness of these legislations, it required a socio-cultural climate of equal social status for females and social acceptance of the female child.

B : Health of the Youth

Demographic Aspects

11. The Conference noted that youth was the most precious resource of the country for the future of the country, but the most vulnerable to physical, mental and social health problems. Youth were the most exploited group due to the politicalization process in the country. The Conference noted that the youth population which was 73 millions or 16.9% of total in 1961, rose to 125.1 millions in 1981 (18.26%) and expected to have risen to 171 millions or 20.5% of the population in 1991. A youth population of 190 millions is projected for the year 2001. Thus the proportion of youth in the population is rising and its health is thus a matter of serious concern.

Context of youth problems

12.The Conference noted that the health services, social welfare services, the teacher community and voluntary organizations should recognize that most youth problems arise from frustration of normal developmental processes of youth. Youth development involves, adaptation to changing social roles from child to adult, adaptation to a sharply rising sexual and aggressive drive due to the hormonal surge, need for self-esteem and self-assertion, seeking self-dentity through peer imitation and peer acceptance. Thus, most youth problems of unsafe sex behaviour, aggressive

behaviour, result from failure of the socio-cultural- economic system to rise to the needs of the youth.

Major Youth Problems

13. The Conference noted that the major youth problems in India included, high incidence of unemployment (67.2% youth are unemployed and non-student); high incidence of major psychiatric problems (12-15% among youth as compared with 5% among general population); high degree of stress and alienation, which is increasing due to rapid urbanization and lack of a sympathetic ear to youth; reproductive health problems (teenaged marriage and pregnancy,teenaged pregnancy outside marriage, sexually transmitted disease - two thirds of STD problem is among youth); AIDS, is reported to be a steeply rising problem in major metropolitan cities and drug addicts of North Eastern States; high rates of anaemia in female adolescents after menarche; accidents (about 15 to 20000 accident deaths and 15-20000 permanent handicaps in youth every year projected to increase to 30,000 deaths and equal number of handicaps every year by 2000); suicide (15000-20000 suicidal deaths every year by youth and 15-20 lakh attempted suicides); smoking, alcohol and drug abuse (10%of male non student youth are smokers. An estimated 3.6% of non-student youth in Chandigarh had experimented with drugs. An estimated 10% of street children of Bangalore City were drug abusers); crime and violence; and, occupational health problems.

Youth is our key resource

14. The Conference noted that youth can be the key resource in implementing programmes for physical, mental and social well-being of the youth. The existing National Service Scheme with about 7.5 lakh volunteers in the country, the Nehru Yuvak Kendras (about 200 functioning in the country), University and College Students Associations, Boy Scouts and Girl Guides, etc., offer tremendous potential for mobilizing youth in implementing youth programmes, female literacy and other programmes of critical national importance.

VII Recommendations

A: Health of the Female Child

Improving the female child's social image

15.The Conference recommended that for improvement of girl child survival and quality of life, the major thrust of the government and voluntary organizations should be to improve the social acceptance of the female child through improving her social image and economic productivity.

16.The Conference recommended that towards the above, grassroot organizations in every village need to be created and sustained, so that these voluntary village level organizations (Mahila Mandals and Youth Clubs) can work with the people and educate them. For this, the anganwadi workers and primary school teachers who are available in every village, can be trained and utilized.

17. The Conference recommended that the Integrated Child Development Services Programme should be strengthened, and innovations introduced in the Programme to improve the girl children's nutritional status and subsequent school enrollment. In addition, ICDS must be introduced in the most backward taluks of the country, some of which continue to remain outside ICDS coverage.

18. The Conference recommended a massive educational effort through the mass media, voluntary organizations, school teachers and anganwadi workers to improve the female image in the society. Some of the educational strategies could be as follows: to reinforce and publicize the historical and mythological women personalities and episodes which depict a positive or prominent role of women; mobilize the mass media and advertizing profes sionals to depict females in a positive manner; a policy decision to allocate a regular time for programmes on the television and radio for female child/women's issues.

19. Towards improving social acceptance of the female child, the Conference recommended that, on a national scale, a scheme could be established to provide old age social security benefits to parents of only one or two female children who undergo steriliza tion operation. This scheme has been started by the Government

of Maharashtra, which deposits Rs.10,000 in long term deposits for parents undergoing sterilization after only one living child, the child being female, and Rs.7000 deposit in case of parents undergoing sterilization after two living children (both females) This deposit is towards payment of old age/destitution pension in future to the parents.

20. The Conference recommended Programmes for vocational training, skills training in economically productive activities for female children, female entrepreneurship development programme, and low interest loans, suitable for rural areas and urban slums. A small beginning has been made through schemes for women launched by the Department of Women and Children's Welfare, but the Department's infrastructure and management capabilities need to be greatly strengthened to execute programmes on a large scale, to work with the community and to coordinate with several other Departments, such as the Departments of Industries, Educa tion, Rural Development and Revenue Departments.

A "Mission Approach" to female literacy

21. The Conference recommended a determined thrust for the critical programme, namely, the female literacy programme, which is critical for the girl child and national development. In fact, the government should think of the "Technology Mission Approach", on similar lines as the Universal Immunization Programme, starting with the most backward 100 districts (or so) in the country, and expanding further. The lessons and success of the UIP in promoting universal immunization could serve as guiding principles. The international organizations such as UNICEF and others could perhaps be mobilized to assist in the Programme.

22. The Conference recommended a few strategies for actualizing in reality, the goal of universal female literacy. One of the recommended strategies was, to provide scholarships and free books to rural low-income-group girl children of backward, low female literacy districts, and urban slums, on their successful entry to middle school, high school and colleges. Another recommended strategy to enable education for female school dropouts and adults, was to utilize the college and university students for this purpose during summer vacation, e.g; on the lines of Annamalai

University's Rural Literacy Programme - each one teach twenty in the rural areas.

23. The Conference recommended a thrust to the Centrally Spon sored scheme of "Creches for children of agricultural labourers in rural areas and urban slum mothers". Creches, financially assisted by the government but run by local voluntary organizations, if properly monitored for eiffciency, have potential to improve continuation of female child education, by freeing the older girl children from the chore of baby sitting.

D. Health and Development of the Youth

Health and Counselling Services Infrastructure

24. Keeping in view the specific health needs of the youth, the Conference recommended *that a network of health, counselling and medical services should be built up all over the country, but particularly in the urban slums where the problems were most acute.* The minimum youth services which should be provided are as follows: Reproductive health services (health education, contraception and abortion services irrespective of martial status and age, special obstetric outreach services to teenaged pregnant mothers, treatment of sexually transmitted diseases); deaddiction and counselling services for alcohol, smoking and drug abuse behaviours; emergency services to handle injuries and attempted suicide cases.

25. Keeping in view the low age at marriage of substantial proportion of females, particularly in the backward districts and States of the country and the urban slums, and the high maternal risk during teenage, the Conference recommended that the Family Welfare personnel could be charged with the responsibility of covering all teenaged wives (if possible) with suitable temporary contraceptive measures. This measure would greatly alleviate reproductive risk, and also act as a substantial population control measure.

26. The Conference recommended that these health and juvenile welfare services should be provided from integrated health and social welfare health posts, which will reduce costs and also ensure a holistic approach to youth problems. Some form of integration of the existing Family Welfare Centres and Juvenile Service Bureaus

(of the Dept of Women and Children Welfare), could be considered, with some minimal additional personnel and infrastructure, and certainly, a systematic training of all health, paramedical and social welfare personnel to successfully implement these approaches. Thus, one could ensure for the community, on a population coverage basis, atleast one full time social worker, who could deal with not only youth problems, but also other social issues.

27. The Conference recommended that , to begin with, particularly in the urban health services, the high risk youth groups and female adolescents should be clearly recognized (urban slums; school dropouts; unemployed; family history of alcoholism, marital conflict; crime and lunacy). These high risk youth should be targetted for special attention, and specific programmes should be targetted to reach out to this group.

Programmes for healthy self development of youth

Conference recommended Programmes for promoting youth employment, self employment, vocational training, youth entrepre neurship development, promotion of work ethic for mental health, low cost sports and other healthy leisure activities, towards promoting the mental health of the youth and rehabilitating youth affected by misadventures. Besides launching the Programmes, close information networking should exist between the Health and Juvenile Welfare Centres and the organizations providing the youth employment and recreational services/facilities.

29. The Conference recommended utilization of youth energy in national constructive activities such as universal literacy, rural development, and any other locally relevant issue, towards promoting the all-round self development of youth, which is fundamental for self esteem and mental health. Such programmes, if effectively implemented, could go a long way in preventing the alochol and drug abuse problems and other mental health problems.

Youth participation in the programmes

30. The Conference recommended that the youth themselves can be the greatest resource to implement the gigantic tasks outlined above. The voluntary efforts of students, local non-student youth

and youth organizations could be mobilized to provide outreach services, after suitable training. Youth participation would also result in effectively bridging the gap between the community and the services. The existing systems of NSS, Nehru Yuvak Kendras, college student associations, Boyscout and Guide associations could be mobilized.

Education for prevention of youth problems

31. The Conference recommended that certain educational compo- nents should be suitably incorporated in school and college curricula, namely, sex education and human reproduction, personal hygiene and work ethic. These topics could be included in moral science, civic sense classes, and health education subjects which have disappeared from curricula of late. For training of school and college teachers in imparting this education, the medical students/interns could be utilized.

32. The Conference recommended that, particularly in medical college curricula and internship, medical students should have a study subject and field postings to study youth problems, practise the counselling approach for prevention, STD treatment and health education. The concepts of "high risk groups" and approaches to meet their needs should be taught to medical students.

Prevention of anemia among adolescent girls

33. Keeping in view high incidence of anemia in adolescent girls, the Conference recommended that School Health Programme should be strengthened with specific budgetary allocation for every PHC, and antianemia services for adolescent girls should be incorporated. Anti-anemia programme for adolescent non-school going girls, should be a regular activity in the general health services.

Enlisting the efforts of voluntary organizations

34. The Conference recommended governmental support to voluntary organizations and utilization of their services and experiences in planning and implementing programmes for the youth and the female child.

Towards more constructive role of the mass media

35. The Conference recommended that a high level task force should be formed to examine the issue of increasing depiction of violence by mass media-films, TV, etc. The Task Force should be comprised of top administrators from health, social welfare, dedicated social leaders of national standing, prominent mass media producers and professionals.The Task Force should try to influence the mass media to move away from projecting violence in films and TVs and to move towards healthy constructive entertainment and projection of value-based themes.

Management systems and initiatives needed

36. The Conference recommended that administrative procedures be established for effective coordination at all levels between the various Departments involved in youth and child welfare. Several Departments are/would need to be involved - the Departments of Women and Child Welfare, Health and Medical Education, Education, Industries, Rural Development, Human Resources Development, Youth Affairs, etc.

37. The Conference recommended that series of workshops should be organized at National, State District and sub district levels for medical, social welfare and education personnel to orient them to the problems and to the approaches to promote health of youth and the female child.

38. The Conference recommended that government and non-governmental organizations which implement innovative or outstanding programmes for youth and female child health, should be given due public recognition and honored at the National, State, District and local levels. Individuals at all levels, who achieve outstanding performance in these areas should be publicly honored just as outstanding teachers, police personnel, etc., are publicly rewarded on Independence Day, Republic Day, etc.

39. With increasing complexity of health problems and consequently the need for professional approaches in health management, it was recommended that an All India Health Service (on the lines of the Indian Administrative Service, Indian Police Service, etc.) should be created.

ISHA 1991 Conference hopes that the planners, administrators and professionals at various levels will seriously reflect and act upon those issues and recommendations which are appropriate for their respective situation, towards health and development of the youth and female child in India.

*****

Prayer for Girlhood

" I am a girl, your daughter,your sister, your friend. I need your help.

I was created by the world to give the world gentleness, understanding, sere-nity, beauty and love. I am finding it increasingly difficult to fulfill my pu-rpose in life.

I would like to be a woman of beauty, inspiration and love. To have love for my children; love for my husband; love for God and my country.

I need your help to restore my true dignity. Allow me to fulfill the purpose for which I was created. I know you can help, I know you can find a way".

INAUGURAL ADDRESS

His Excellency Shri Bhishma Narayan Singh, Governor of Tamil Nadu.

It gives me great pleasure to be here this morning to inaugurate the 11th Annual Conference of the Indian Society of Health Administrators. I am happy to learn that the Society established in 1979 is striving to bridge the gap between availability and need for health services in India through professional development of Health administrators. It has been organizing annual conferences on various topics of importance in health administration and has been making various recommendations to the policy makers. I am happy to note that they have chosen the theme 'Health of the Youth and the Female Child' for this year's Conference. The Youth and the girl child are among the most vulnerable groups and great attention is required to be paid to this group if we are to build a modern India and achieve the target of 'Health for All' by 2000 A.D.

The importance of the health of the children, their special health problems, and the care and attention that is required has been recognized worldwide for several years now. The year 1979 was observed by the United Nations as the year of the Child. Twenty years before that the ' Declaration of the Rights of the Child' had been adopted. There are certain additional problems faced by the girls in the SAARC countries and realising the importance they, including India, highlighted the special problems relating to the girl child and declared 1990 as the year of the Girl Child.

In India there is great discrimination against the girl child even before her birth. Sex-detection tests have been used to prevent births of female children. Th ese sex-determination tests which were prevalent in Bombay city soon spread to other towns in various parts of India as well. It has been estimated that, between 1983 and 1988, nearly 30,000 to 50,000 female foetesus were destroyed each year. Fortunately certain well-meaning people in the society, sociol-ogists and the women's organizations rose against it. The Maharashtra Government passed a Regulation on use of pre-natal Diagnostic Techniques Act". This bans the use of such tests except in certain specific cases. Though the Maharashtra legislation and the general concern voiced forth by various forums have apparantly reduced this abuse of sex-detection tests, it cannot be said with certainty even now that this abuse has

been given up. The proliferation of this test in various States brings to focus the need for a comprehensive Central legislation in this regard. There is also an urgent need for proper evaluation of the tests today. Those in the medical profession have a great role to play in this. It is only they who can prevent this than what any amount of legislation can do. The doctors have a responsibility to the society and the un-born girl child and should try to eradicate this evil in our society. Coupled with this there is need to remedy and alter the social prejudices against the girl-child. That our social ethos is responsible for this malady is clear from the fact that sex-determination tests are used by the Indians abroad also. It has been reported that a Californian doctor used the sophisticated ultrasonic technique to determine the sex of the foetus and advertised it through newspapers, leaflets and by direct mailing in Punjabi and English to the Indian population. My first appeal to the people would therefore be to stop these practices and allow the female children to be born in this earth.

The travails of the female-child continue after her birth. Various studies on children and women indicate a negative female ratio to male, higher mortality and morbidity of the female child, lesser access to food, health, education and an early induction into domestic work, marriage and motherhood.

The census figures show a continuous decline of the female over the male, indicating social prejudices against the female. In the 1901 census the number of women to 1000 men was 972; this declined to 933 in 1981 and 929 in 1991. As regards our own State the sex ratio. which was 977 and 1981 has now declined to 972. This is against the world-wide trend and needs correction by providing adequate health care, education facilities and acceptance of the female child in the society.

It is therefore not surprising that the mortality among the female children except in the first few months of life, is higher in our country which is in contrast to the picture in developed countries. The female children by their biological nature are stronger than the male children and therefore the higher mortality is to be explained only as due to under-nourishment, malnutrition and lack of access to health services. From the papers published by the Census of India in 1988 on the child mortality estimates, it is seen that out of 402 districts, female mortality upto the age of two is greater than that of males in only 142 districts. But this increases to 172 at the

age of three and at the age of five the female mortality is higher in 224 districts.

In order to change this scenario, to provide the female child her due, it is necessary not only to promote better economic conditions but to have a change in social attitudes. The status of women in the society has to improve. While the roles assigned to the boys are as providers of the family in future, the roles of the girls are centred around marriage and motherhood. Girlhood is looked upon only as a training ground for the role she is expected to play as a wife and mother later. This social role assigned to the girls stunts the growth of their individual personality. This is so even in the case of women who are economically independent. Economic freedom has not necessarily provided them with social freedom or emanicipation. This is evident from the fact that the women who contribute to the family income whether by going to offices in the cities and towns or as labourers in the fields, in the villages, are not spared of the household chores as these are thought to be the sole responsibility of the women. This social attitude brings with it social prejudices against the girl child. Therefore the health problems of the girl-child are to be tackled not merely as a medical problem but as a social problem as well. An integrated approach by the medical personnel, sociologists and psychologists is therefore needed for the betterment of the health of the girl-child.

The youth in India are one of the most vulnerable groups on whose health great attention should be paid as the prospects of growth of the country depends on them. It is a group which can easily be exploited and therefore has to be guarded carefully to bring out the best in them.

Several health problems of the youth are emotion-related problems, mainly because of the distinct phase of adolescence calling upon new challenges, to adapt to new situations.

It should be borne in mind that the youth are a valuable resource for providing health for themselves and for others and whenever health-policies are formulated for the youth they should be involved in the decision making processes.

With these few words, I have great pleasure in inaugurating this Conference.

1. THE FEMALE CHILD IN INDIA

- Keynote Address

*Jayakothai Pillai**

I Introduction

The United Nations declaration on the Rights of the Child(1959) maintains that "mankind owes to the child the best it can give". The U.N. convention of 1989, the most exhaustive, international expression of children's rights starts with the statement "Children because of their vulnerability, need special care and protection". The human rights of the child includes civil, political, economic, social and cultural rights. The civil rights under the convention include the right to a name and nationality, protection from torture and maltreatment. The economic rights include the right to benefit from social security, the right to a standard of living, and right for protection from exploitation at work. The social rights include the right to the highest attainable standard of health and access to medical services, the right to special care for handicapped children, protection from abduction and social exploitation, and, regulation of adoption. Cultural rights include the child's right to develop fully thr ough education.

II The Child In India

In the Indian context, let us examine how far the rights of the child are protected. Even the most fundamental right - the right to survive is not discharged properly. Approximately 4.2 million children die in India mostly from preventable diseases. The average infant mortality rate in the first year of birth is 10% and in the slum areas it is 12.4%. Children dying because of malnutrition before the age of five years is about 40%.

India ranks 30th among countries with 152 deaths per 1000 live births. The most important reason for this high death rate of children is that the majority of Indian children are vulnerable and deprived of medical and rehabilitation facilities. The energy intake of children from rural low income families is found to be 30% below the recommended levels. Nearly 85% of Indian children suffer from varying degrees of malnutrition. About 63% of children below three

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years and 45% between three and five years suffer from iron deficiency and anaemia. Thousands of children go blind every year by the deficiency of vitamin A. Only 15% of the population has access to hospitals.

According to a UNICEF survey report of 1984, in India, there were 2.5 lakhs blind, 2.5 lakhs deaf and five lakhs orthopedically handicapped children. Neither the Government nor the voluntary agencies have been able to even touch the fringe of this problem of growing incidence of childhood disabilities.

The number of destitute children is rapidly increasing with the collapse of the traditional family and social structures. Welfare services for such children is almost negligible. A rough estimate is that the total number of orphan children would be around 30 millions.

Among the world's working children, Indian children constitute the largest number, anywhere around 16 to 17 million. These children work from 6-12 hours a day and they are employed in agriculture, industry and domestic work.

When we consider education, we find that illiteracy, ignorance and low status of women have direct bearing on children,their health and education. Areas where there is low female literacy, are also characterised by underdevelopment, low employment, low per capita income, low nutritional level with heavy concentration of scheduled communities and landless agricultural workers. Low female literacy is highly correlated to high fertility rates, high population growth rate, and high infant and child mortality rate. There is a high association of female literacy with female age at marriage, life expectancy, participation in modern sectors of economy and female enrolment in schools.

Even after four decades after Independence, all children of 6-14 age group are not in schools. Only 56.3% of the boys and 30.6% of the girls of the relevant age specific population have been enrolled. Nearly 1/5th of the total habitations have no schools of their own. And even where schools exist, 40% have no pucca building, 39.72% have no black boards, 59.5% have no drinking water and 35% of the Schools are single teacher schools. (National Policy on Education Documer', 1986).

Primary education has not improved qualitatively in most of the rural and backward areas. The subjects taught are not related to the environment of the children; the methods of teaching are outmoded, rigid, and uninteresting; work- based or activity-based education has not been implemented. All these have led to dropping out of the children from the schools. Of 100 children enrolled in Class I, only 23 reach class VIII,attaining the desired level of literacy.

III The Female Child

Girl children today are targets of attack even before they are born. Even among the educated, urban, well-to-do people, advanced medical technology such as amniocentesis and ultrasonography are used and frequently if the foetus is found to be female, abortion is induced. In a sample study, 7999 of 8000 foetuses aborted were female. According to a Times of India report in June 1982, in the four years after the introduction of sex detection tests in our country between 1978-82, 78000 female foetuses were aborted. Even before the girl child is born, parents view her as a liability. This attitude is rooted in a complex set of social, cultural and historical factors. The dowry system, economic dependence of women and social customs and traditions are the main causes of the neglect of the girl child and discrimination against her.

As the girl child is viewed as an economic burden and social responsibility, she is unwanted and her arrival is not considered as a joy and discrimination begins immediately after birth, with respect to feeding practices, health and medical care. Various reports on the duration of breast feeding indicate preference for longer feeding for boys; the interval between births is shorter after the birth of a girl than after the birth of a boy, indicating a shorter period of breast feeding for the female child(Helder & Bhattacharya 1969).

Among some groups, it is reported that the ceremony of annaprashana, i.e. giving the first solid food, is earlier for girls than for boys, indicating a shorter duration of exclusive breast feeding.

It has been brought out by Miller in his book "The Endangered Sex (1981)" and confirmed by the Operation Research Group of Baroda (1986), that there was a definite preference favouring boys with regards to eggs, milk and butter.

There is considerable evidence of higher morbidity among girls. Dandekar, in his survey of rural communities found that the percentage of children getting no medical treatment was higher in females. During an observation period of one week at a primary health centre, Khan observed that 43 boys attended the ce ntre as compared to 15 girls and discrimination against girls increased with their number in the family. Child mortality data shows a bias against females. Taking the first five years as a whole, the death rate of female children was 74 per 1000 while the death rate of male children was 50 per 1000. Girls less than two years old had substantially smaller chances of survival than boys of the same age. A comparative study of child mortality notes that in the overall pattern, there was poorer child care for female children in the Northern as compared with the Southern States, but recent report from Tamil Nadu about female infanticide in Madurai district, indicates that the situation is not very favourable in the South either.

It is also found that there is no linkage between the prosperity of a family and the status of the girl child. In Punjab and Haryana, for instance, the mortality of the girl children is striking despite the high per capita income. Higher mortality rate among girl children leads to an adverse sex ratio. It is alarming to find that the sex ratio has further declined from 933 in 1981 to 929 in 1991, per 1000 males. We need to organise mass campaign to raise social consciousness in favour of the girls among all sections of people.

In the rural areas, about 70% of the non-starters i.e. those who have never been to schools are girls. As mothers regard the role of the girl child as a second mother to look after the younger siblings and to shoulder the responsibility of household work, (fetching water, fuel, fodder, cleaning and cooking), the girl child gets handicapped and conditioned by the attitude of the mother and the family, and the traditional sex role, and going to school becomes secondary. The economic value of the girl child, to the family and to the society is never recognised. According to a U.N. report, on an average, a girl in the Third World countries, works for 9 hours a day for 315 days in a year in the home and in the fields, as unpaid labour and by the time she ceases to be a child, she renders economic help worth Rs.39,600 at minimum wages surviving on substandard food and struggling against prejudice and discrimination.

When the father or brother is a drunkard, the girl child, in many cases, is physically assaulted and abused. These traumatic experiences leave a lasting impression on the girl child. There are quite a few instances of sexual abuse of the girl child, of her being seduced and led into prostitution, of unwanted pregnancies and sexually transmitted diseases. The incidence of child marriage continues inspite of the legal prohibition. This leads to early pregnancy, and puts pressure on the child to play adult roles.

There are any number of social prejudices against the girl child. A proverb goes like this, "Bringing up a daughter is like watering a plant in the neighbour's garden". In the census data of a village in U.P, it was found that the village women did not bother to include girls in the number of children. The reason stated was that girls have only temporary membership in the parental home, they are considered as guests in their native village and that they would be sent away in marriage, bonded to some other village as soon as the parents can arrange. It was also considered unnecessary to spend money on girls on their health or education. The female child, in Indian culture, is expected to cultivate the qualities of inferiority, subservience and domesticity which place severe limitations on her growth and development.

During the years 1971-81, girl child labour increased four times as that of boys. Thus the initial investment on the girl is well below the minimum prescribed in any charter of human rights. The female child population in India is around 160 million today and is the most vulnerable group.

IV Conclusion

The greatest single factor which can improve the status of the girl child is education - education of the girls, their parents, and the society in gener al.

There is lower enrolment of girls in schools and higher dropout rate from the schools. According to the latest statistics, two out of every ten girls in the age group 6-11 are still not enrolled in schools. The incidences of drop out and stagnation amongst girls is nearly twice that of boys. The Government have set up anganwadis, balwadis etc. to look after the younger siblings of the school going girls. The nutritious noon meal scheme with all the package benef its of free education, free books, free uniforms etc. have also

contributed to some extent to the regular attendance and retention of children in the schools in Tamil Nadu. These should be strengthened.

Nutrition and health care should be adequately taught in schools. Adolescent girls should be trained in fertility awareness education so that they have the knowledge and skills to prevent molestation and rape. Girls should be trained in vocational skills and should be educated with a view to achieving ultimate economic independence.

The electronic media should launch a campaign of educational inputs to depict the girl child in a positive light. This would help in changing the socie ty's attitude towards girls and their roles.

The print media should give enough space or priority to reports on health and nutrition. Discriminatory advertising should stop both in the print and electronic media.

In short, girls should be helped to grow up to be human beings.

It is high time we started thinking of the importance of nutrition and hea lth status of women as individuals, and in terms of human resource development and not only in terms of her maternal status.

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2. HEALTH OF THE FEMALE CHILD IN INDIA.
- Keynote Address

*Banoo J. Coyaji**

I Introduction

India became independent in 1947,drew up a magnificient Consitution and embarked on planned economic and social development. It is worthwhile to take stock of our progress in women's health in general and the female child in particular at the end of the VIIth Plan, as we enter the crucial decade of the nineties.

II Situational Analysis of the Female Child in India

A: Demographic

The preliminary figures of the 1991 census as declared by the Registrar General of India and Census Commissioner in the last week of March are to say the least, not reassuring. India's population has touched 844 million, just 160 million short of the daunting 1 billion mark with a decadal growth of 23.5 percent and a birth rate of 32.33. Dismal as these figures are, the most distressing fact is that the sex ratio has actually fallen from 934 in 1981 to 929 in 1991 (1).

At the beginning of the century the sex ratio i.e. the number of women to 1,000 men was 972 and it has steadily fallen over the years to 930 in 1971, with a marginal rise to 935 in 1981. It gave us some hope that something was being done for women. Our hopes have,however,been belied and the ratio is now 929(2) actually 6 point lower than 1971-2 decades ago. The optimists among demographers say that there may have been under-reporting of females especially among minorities in the troubled States and the situation may not be as bad.

In spite of the innate biological advantage of the female of the human species, the age specific mortality reveals that for all ages upto age 35, female mortality is greater than male. There is great disparity between the Northern and Southern States, between rural

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and urban areas, lower and upper socioeconomic classes, in terms of health, nutrition and education status of women.

The female child health issues can only be tackled with a life cycle approach. It starts with the girl embryo in her mother's womb. Its survival and growth will depend on maternal nutrition, freedom from infection and disease, and unhealthy practices of smoking and drug abuse. Other factors include, availability and accessibility of good antenatal, natal, and postnatal care, and, her knowledge, willingness and social support to utilize that care. Breast feeding the girl child, adequate nutrition, rearing, immunizing, growth monitoring and educating her through childhood and adolescence to marriage and pregnancy at an appropriate age, complete the cycle. The subject encompasses the present world strategies of Maternal & Child Health, Child Survival, Safe Motherhood and Family Planning.

India, with other nations of the world, has committed itself to the 'attainment by all citizens by the year 2000 A.D. of a level of health that will permit them to lead a socially and economically productive life'. This goal is impossible to reach without giving priority to women's and female child's health needs, not only because women form half the world's populati on, but, also, because their health and well being is the key to the health of their families and the health of today's and future generations.

Both men and women suffer from the effects of socioeconomic inequity, local, national and international. Women in addition, have to bear the consequences of their inferior position in society as women. Women are not merely producers of babies. They have multiple roles, as workers, wives, mothers, members of the family and community, and these compounded by their inferior social status, have a profound effect on their health. Health of women is not only a medical issue. Their health depends on various factors such as nutrition, availability of clean drinking water, healthy environment, habitat, fuel, sanitation, social support, access to economic resources and decision making bodies.

Women are discriminated against from the cradle to the grave-no, even before they are born. Due to preference for sons, in some societies,technologies like amniocentesis are misused for sex determination, followed by induced abortions of female fetuses. Female infanticide may be disappearing but parental neglect of

female babies is real. Girls are breastfed for a shorter length of time. When ill, they are given less medical aid and less promptly. They have less opportunity for education and training for gainful employment than their brothers.

It is not surprising that the nutritional status of the female child is poor as compared to the male. Figures from several nutrition studies all over the country show that there is more malnutrition among girls and severe malnutrition or marasmus is nearly three times as much. There is considerable evidence of a higher morbidity among female children. Yet if you look at admissions in hospitals there are more boys admitted than girls. The boy child will be brought to the doctor with the first sneeze while the girl child will have to wait till she has pneumonia. This childhood deprivation syndrome effectively suppresses the physiologic adolescent growth spurt. So these girls grow up malnourished, anaemic, stunted in height and growth.

3: Mortality

The statistics on children in India prepared by the National Institute of Public Co-operation and child development 1990 reveals that age specific mortality for all age groups from 0-14 is higher for females than males with rural rates being still higher and the expectation of life at birth lower.

Even in the ICDS and UIP programmes it has been observed that more boys are brought than girls. Another fact stares us in the eyes, with Life tables from the Registrar General's data showing that except for age 0, the mortality of females at each age from 1-19 was higher than that of males in each census. We were hoping that it would change in 1991 but with sex ratio having fallen by 5 points from 934 to 929 it is wishful thinking.

C: Reproducitive Health of the Teenaged Female

The health problems from which Indian women suffer are compounded several fold in the younger woman who is pregnant, particularly in the age group 13-19 years. Considering, that nearly 40 percent of India's population of 840 odd millions is under the age of 14 and that marriage is universal, the problem of teenage pregnancy affects the life of a good percentage of women. The mean age of marriage is slowly increasing from 15 years in 1951 to

18.2 in 1981 (3). Even so, a large proportion of girls, specially in the rural areas, are already pregnant in their teens. About 2 out of 3 girls aged 15-19 in the northern States of India where the average age of marriage is still 16.5, are already married.

Pregnancy in the teenager is more dangerous to both the mother and child than pregnancy in the 20s. National data is not available for maternal mortality at different age groups. The available data reveals Maternal Mortality Rate to be between 300 and 450 per 100,000 live births with wide variations ranging from as low as 40 to 1,340 in different States and urban and rural areas (4). Several hospital based studies confirm the dangers of teenage pregnancy. Statistics all over the world reveal that the maternal mortality is higher in the age group 15 -19 and particularly so under 17(5). The risks are the greatest for the very poor who have the worst diets and least availibility of antenatal care(6). The Jamaica and Nigeria studies show that women younger than 15 are four to eight times more likely to die during pregnancy and child birth than at 15-19(7). Even in the U.S.A in 1977, the maternal death rate under 15 was 2.5 times greater than in the age group 20-24(8).

The major life-threatening complication for every young mothers are pregnancy induced hypertension, iron deficiency anaemia and cephalopelvic disproportion.

Pregnancy induced hypertension is a "special hazard". It occurs more often among primigravidas. Its incidence is five times higher in the age group below 15 than in the age group 20-24. It is serious and if untreated can cause convulsions, congestive failure, cerebral edema and death(8).

Iron deficiency is a special risk for the young mother. Adolescents,who beocome pregnant within four years of menarche, are physically and physiologically immature and, since they are still growing, will have greater nutritional requirements than adult women. Indian girls, specially living in rural areas and of economically deprived classes, are already malnourished. Anaemia is common in the first few years after menarche, even among those who are not pregnant. With the growth rate around the time of puberty, the beginning of menses and poor nutrition, pregnancy depletes the body's iron reserves, aggravating the anaemia and malnutrition. This maternal malnutrition has been imp- licated as a

causal factor in pregnancy induced hypertension, abortion,premature labour, abruptio placentae and haemorrhage.

Cephalopelvic disproportion occurs in very young mothers since pelvic growth is not usually complete until several years after menarche. Childhood nutritional deprivation will also be responsible for stunted growth and small pelves-rachitic or otherwise. This causes higher proportion of abnormal presentations and prolonged labour, necessitating caesarean section. Non-availi- bility of this service promptly, in a village setting, wil result in obstruc- ted labour, ruptured uterus, maternal and infant death. Lesser but distress- ing complications may be vesico vaginal and other fistulae.

D. The Young Mother and her Child

The infant of the young mother is more likely to be of low birth weight which is a major cause of infant mortality and morbidity. Innumerable studies report higher rates of prematurity, perinatal, neonatal and infant mortality in children of mothers under 20 than among infants of mothers 20-29 - the rate is 50% higher in some countries like Bangladesh, Pakistan etc(9).

The higher risk of complication and death of children of adolescent mothers persists through early childhood. These children lag behind other children in growth, cognitive development and school performance.

Daughters of young mothers are more likely to become young mothers themselves(10) and so the vicious cycle goes on.

E. Early Age of Marriage

In India pregnancy out of wedlock is not as common as in industrial societies. It is the early age at marriage itself and consensual union soon after menarche which is the problem. Tradition and culture enjoin universal marriage. Poor, rural parents may be making valid decisions when they get daughters married early. Girls are left alone looking after siblings when parents are in the fields. Fear of pregnancy following their molestation, abuse and rape is very real.

Women who marry early tend to have larger families as they are exposed to the risk of pregnancy longer than women who marry

later. Women are more fecund between the ages of 18 and 24 and coital frequency is likely to be higher. The chief demographic limit on early fertility is age at marriage. Even delaying marriage by two or three years can make a difference in completed family size.

The young married woman is unfortunately not really accepted in her husband's home until she produces a child, and that too a son. It is difficult to induce her to use a contraceptive. Seventy percent of women who marry young have atleast one child before the age of 20. She might be willing to use contraceptives after she has delivered atleast one son.

Cervical cancer is on the increase. Girls who start sexual activity early and who or whose partners are promiscuous are at special risk. There are practically no facilities for screening of high risk groups and for early diagnosis and treatment.

Very little attention is given to the mental health of the young married woman. The psychological trauma of sex and pregnancy before the young girl is emotionally ready, and such social evils as physical abuse, wife beating, sexual harassment, rape, dowry deaths and suicides add to her innumerable problems.

F. Educational Status

The educational status of women is also very poor. During the decade 1981-91, literacy rates improved from 43.5% to 52.5% but the gap between male and female has not narrowed. Although enrollment of girls at primary level has increased from 62 percent in 1975-1976 to 81.5 percent in 1984-1985 and at midlevel from 23.3 percent to 36.8 percent, the distressing fact is that 74 percent of girls in the 6 -14 age group quit school and lapse into illiteracy.

Thus it will be seen that a great majority of our girls reach adolescence and womanhood illiterate, or at most semiliterate, with no skills nor knowledge to prepare them for their roles as mothers. The rural health services are poor, but what is available is not being utilized. These young illiterate mothers and their families are not aware of these facilities, nor do they understand their significance. It is not surprising that uptake of MCH, Immunization, family planning, water and sanitation programmes is so poor. It is sad but true that these girls, on the threshold of marriage and motherhood, on whom will depend the health and well being of the most

precious of our human resources - the children of the next generation, form the segment of our population which is most neglected. It is doubtful that the much vaunted new education policy will remedy this state of affairs in the foreseeable future. Similarly the legislation fixing the minimum age of marriage will continue to remain on paper unless we address ourselves to the underlying socioeconomic factors.

III Policies and Programmes for Health of the Female Child

"What then can and should be done?" If laws could guarantee their own enforcement, there would never be injustice. On paper, the rights of the girls and the women are unequivocally protected and enshrined in the Constitution of free India. However, Indian Society at large, stands indicated for the lack of the relentless effort necessary to transform these good intentions into practice. Four decades after Independence and more than a decade after a National Policy for Children and a National Plan for the Development of Women were adopted, the girl child, who embodies both youth and womanhood, is still a barely discernible shadow on the periphery of national policy and public awareness. This discrimination is born of cultural and religious values that spring from the patriarchal, patrilineal Indian ethos which operates more powerfully in some parts of the country than in others. Family structures and values function in such a way that daughters grow up looking upon themselves, as inferior and subservient, entitled to much less of everything than sons, less opportunity, less authority, less property and less status, less power and virtually no choices. The girl child's perception of herself and her role is conditioned by her early socialization, a process which eventually moulds her into the sterotyped prisoner of her gender. There must be a relentless effort of all society to undo the injustice of centuries - The operative world is All. We must shame the politicians, religious and socal leaders, and policy makers into action by a well targetted campaign, utilizing a range of information, education and communication to men, women, boys and girls through all media, T.V, radio, lay press and all culturally appropriate channels to bring about this social awareness and social transformation.

We must mobilize political will and commitment. The impetus for action can only begin with the people themselves from the women leaders and women in general. We must generate public consensus on the need for action and convey and reinforce

messages about the problems and strategies to remedy them. Sensitizing men about the issues and mobilizing their support is absolutely essential.

An integrated and holistic approach to the girl child's development is essential for the creation of a new environment in which she can be valued and nurtured. Our search for brave new efforts to give the girl child her due and to allow her to evolve to her full potential, involves a process of social moblization that will make her everyone's concern, the media, the family, the community as well as Government and voluntary agencies. By supplementing formal schooling with non-formal education that conforms to local needs and constra ints, by enlarging the ambit of child development programmes, with the creation of new channels to reach pre-adolescent and adolescent girls, by reinforcing constitutional mandates through awareness of the rights of girls, these are some of the ways that can empower the girl child and consequently the woman to enter the mainstream of economic and society activity. This will help her to walk out of the maze of neglect in which she has been lost for centuries"(10). Without this all other programmes will come to nought.

The I.C.D.S.Scheme gives an excellent opportunity where the importance of the girl child and her special needs can be reinforced. The Anganwadi workers must see that girls are brought and get tender loving care. It would be ideal if Mahila Mandals were to take over the supervision of the centres to ensure true community participation.

There are enough studies that point unequivocally to the positive impact of women's literacy and employment on maternal mortality, on the birth rate, on acceptance of family planning, neonatal infant and child mortality, nutritional status and on women's health in general. There is right in our country the shining example of Kerala and to a lesser extent Tamil Nadu and Goa. What does the 1991 Census reveal ?. Though the literacy rate has shown a rise from 43.5% in 1981 to 52.5% but it also shows that the gap between males and females has not narrowed, that 60 percent of our women are illiterate - there are districts where this percentage is 80-95%. There is no doubt that the Government of India has, under the influence of Alma Ata, the International Decade for Women and the Nairobi Forward Look Strategies, taken gigantic steps for the advancement of women. A National Perspective Plan for Women

1988-2000 has been developed which shifts the emphasis of women's programmes from welfare to development. The plan aims at health education, development and integration of women into the mainstream of the economy with equity and justice. But strengthening the health services and even the social supports are not enough. The major obstruction is women's own low selfworth. It is necessary to improve the self image of woman. It is too late to do this when she becomes a mother, not even when she is about to become a mother. Self image encompasses the two import- ant areas of self-concept and self-esteem. It depends on the impressions a child receives from her immediate environment and her home and these have a major effect on judgement of self-worth.

The Integrated Child Development Scheme of the Government of India addresses itself to all children, male and female, in the age group 0-6. The M.C.H. programme looks after the pregnant woman and her infant. But there is no project for the age group 7-19. These girls are our future home makers. Their attainments and competence will be the major determinants of the health and nutrition of tomorrow's children. Unfortunately, it is precisely this segment of our population, that has been sadly neglected in our health and development programmes.

There are quite a few innovative research projects addressing themselves to this problem. We in the Vadu Rural Health Project have started 'Young Women's Centres'. We were emboldened to do this after our experience of an experiment at the I.I.E. in Pune of developing non-formal education for school dropouts in the 9-14 age group. This was an experiment in Education and Health For All - "Education for better living". A suitable curriculum was evolved and simple teaching, learning materials were developed. Language, practical mathematics, useful in day to day life, social studies, simple science, reasoning, art, play and music were introduced. Awareness of health, and acquisition of healthy habits were stressed. Health messages like personal hygiene, clean water, cooking, storage of food, nutrition, child care were incorporated. Al together 4,332 pupils, of whom 3,237 were girls in 20 neighbouring villages and hamlets, were involved in this experiment. With the girls came their mothers, grand mothers, brothers and fathers. It is amazing to see how much could be achieved by only two years of non-formal training of just two hours a day. Following a pilot study at the Vadu Rural Health Project of K.E.M. Hospital in October, 1988, an I.C.M.R. Project has been

started in five States involving 150,000 girls in clusters of 18 villages in each State. If the experiment shows promise, as hoped, it will be incorporated in the National Programme in the VIII Plan starting in 1991.

For improving Women's Reproductive Health, strengthen the health services by all means. But, first and foremost, strengthen the woman. Overall societal and male attitudes must change. Women must give up the tacit acceptance of their lot. Only then will they gain the health, development and freedom guaranteed to them in the Constitution of free India.

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3. HEALTH OF THE FEMALE CHILD

- Keynote Address

*Sarojini Varadappan**

I Introduction

The constant neglect of the Girl Child has been haunting society for quite some time and global attention has been focussed on her economic plight and social degradation. In SAARC Year of the Girl Child-1990, an all round concerted effort by the Government as well as voluntary sectors is being made to emphasise the need to bring her into the mainstream of the society.

At the World Summit for children held at the United Nations, 29th and 30th September '71, heads of State or Government agreed to the Declaration and plan of Action. By doing so they committed themselves and their Nations to carrying out specitic actions for children and their mother, aimed at achieving numerous goals during the 1990's.

Among these were, reducing infant and child mortality by a third, reducing maternal mortality by half, reducing by half, severe and moderate malnutrition, providing universal access to safe drinking water and sanitation, universal access to basic education and with emphasis on women's literacy.

The Summit came in the same month that the convention on the Rights of the children came into force, providing further momentum to actions on behalf of children. Families, communities, local Governments, NGOS, social cultural, Religious, business and other Institutions, including the mass media, are likewise urged to play an active role in support of the goals for children set forth in the plan of Action. All forms of social mobilization, the plan states, including the effective use of the great potential of the new information and communication capacity of the world, should be marshalled to convey to all families the knowledge and skills required for dramatically improving the situation of children.

In urging each country to improve its capacity for collecting and analizying data about children, the Plan of Action stresses the

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importance of monitoring the impact of programmes on girls and women so that any inequalities can be corrected. It is particularly important that poliy makers be quickly alerted to any adverse trends in human development so that corrective action can be taken, just as is now done with indicators of economic developments. Each country is urged to reexamine its current arrangements for responding to natural disasters and man made calamities which often afflict women and children the hardest.

Research should be stepped up in the field of health, improved vaccination technologies, malaria, AIDS, respiratory infections, family planning and care of the new born. Also in the areas of early childhood development, basic education, hygiene and sanitation.

The girl child is considered to be a lesser child in our society. She continues to be neglected at all levels and discrimination against her is rampant in all strata of Society. She is an unknown intrusion, the cause of sorrow when she is born, a burden for parents who have to amass a dowry. The one who has to be fed less than her male, counterparts. She is also the convenient workhorse.

The existing national canvas indicates adverse female male ratio, low nutritional status, high female infant mortality rate, low enrolment of girls in school and high rate of school dropouts amongst girls. A high rate of participation in the unorganized sector, lack of vocational skills and training, and unacknowledged contribution in the household and national economy, are other indications of her low status, and society has the support of religious mythological sanctions and traditional practices in our highly structured and restricted society social norms and community taboos, are successfully keeping the girl child invisible with a deeply embedded social bias in favour of the male child.

It is necessary to understand the demographic profile of the girl child to assess fully the problems and issues relating to her. The demographic profile reflects disturbing contours of decreasing sex ratio, high rate of maternal mortality and high rate of infant mortality among girls. 13% of female deaths before the age of 24 years are due to the complications during pregnancy and childbirth which has a direct linkage with low health and nutritional status of the girl child in childhood and also subsequently child marriage. Out of 12

million girls born in India every year, 25% of this do not reach the age of 15 years.

II Health and Nutrition

Poverty deprives a child of what ought to be her basic right. In a society where resources are scarce; the needs of the girl child are the first casualty and are being neglected and ignored in health care, nutrition and immunization. She gets poor food, insufficient nutrition and inadequate medical care. The mortality rate is higher among girls due to the systematic and delibertate discrimination right from the birth. Now even prior to birth female foetuses are being discriminated.

Female infanticide is being practised in many parts of the country in one form or other. In Rajasthan there were reported cases of prevelance of the practice of murdering the daughters of the family. According to the Press reports, the Killas of Usilampatti Block in Madurai District of Tamil Nadu are continuing with the practice of female infanticide, where the girls immediately after birth are consigned to customary death with the poisonous milk of oleander berries.

Studies show that the girl child is breast fed less frequently and for a shorter span than boy, more so when a mother wants to conceive early for the desire of a son. As a practice, specially in the rural areas, the girls are given home remedies and not taken to hospitals or Primary Health Centres.

High infant mortality rate among girls is the direct indicator of inadequate medical care. According to a recent study, infant mortality among children upto 5 years of age is much higher among girls. Discrimination against the girl child in health and nutrition is rather striking. Studies show that girls in all age groups are found to be more malnourished than boys partially because of more work and less food. There is a general practice, especially in rural areas, that the women and girls of the family eat last, after the men folks and sons, which means eating less quantitatively and qualitatively. This is mainly because of the socially enforced value that men are the bread winners and assets whereas the women and the girls are liabilities.

Girl children form about 50% of the child population and contribute to a great extent to the growth and development of the

Nation. As an equal contributor, she should get equal share of food and health care from birth to adulthood. The human rights demand that the practice of the killing of girl infants should be abolished.

III Social Action for the Girl Child's Development

Socio-religious, cultural factors influence the upbringing of the girl child right from the birth and restrict her role in the primary groups such as family, neighbours and friends and also her inter-actions in the larger society.

To combat these factors, awareness should be brought about through illustrations from and religions literature like Ramayana Mahabharata, Bible, Quran, etc., referring to the equal status of girls and women. Presentation of folk lore should always be with the positive image of the Girl child. Passages from the writings of social reformers and thinkers who had promoted the rights of the girl child be given wide publicity through text books and other literature. Excerpts from the writings of Mahatma Gandhi, Tagore, Dr Ambedkar could be used for this purpose. Success stories of women in the Indian history should be widely publicised. Contribution of the girls in household in National Economy should be given wide publicity so that her image as a liabil- ity should fade.

IV Conclusion

The strong need is to bring out attitudinal changes among parents, families, functionaries of educational institutions, and among the girls themselves, to improve the self image and self perception of the girl child. Exhibition of the posters on the girl child can be arranged.

I have made some observations and suggested few actions towards health of the Girl Child. Now it is open for you, the experts to react and make your observations on this subject. I thank the Organisers of this Society for having invited me to give the Key Note Address on this subject. I am sure the outcome will be of great help to improve the image of the Girl Child in view of the SAARC declaration of this year as the Year of the Girl Child.

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4. HEALTH OF THE YOUTH - PERSPECTIVES, ISSUES AND FUTURE DIRECTIONS

- Keynote Address

Ashok Sahni and Sudha Xirasagar**

This paper presents the perspectives and issues relating to health of the youth, approaches and suggested future directions for policies and programmes towards promoting healthy development of our critical national resource at risk-namely, the youth.

I Introduction

The year 1985 was declared by the United Nations as the International Year of Youth, keeping in view the growing concern about the health of youth. The concern originates from several factors. Youth, particularly, in the developing countries are being recognized as a high risk group as far as physical, mental, social and spiritual health is concerned. Secondly, the health and psychosocial experiences of youth profoundly influence the present as well as future national ethos, health and productivity. Today, the youth in India are growing up in a transitional society influenced on the one hand, by a larg ely traditional home background, and on the other, by the compelling forces of the economic, social and physical environment around them, forces which are shaped by progressive industrialization, rapid urbanization, westernization of values and politicalization. These forces, in interaction with the unprecedented population explosion, accompanied by low rates of growth of opportunity and income, further threaten the mental and socioeconomic well being of youth. As a result of these complex environmental factors and the innate developmental problems of adolescence, the youth in India are facing increasing health problems. Thus the health problems of youth can be attributed partly to environmental factors, but much more to the psychosocial and behavioural response of the youth themselves. Massive urbanization is expected to take place in India during the coming decades, with the urban population expected to go up from the present 25% of the total population of 45%(nearly 360-450 milions)

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by 2000. With this phenomenon, the youth problems are likely to escalate rapidly.

In the background of the national and international concern for health of the youth, is the compelling demographic fact that the world (and India's) population of youth has been increasing disproportionately, and would continue to increase upto 2000. The absolute numbers of youth in the total population would increase beyond 2000 until the population stabilizes around the year 2050 or so(1). Keeping in view the sheer numbers of youth, it makes economic and moral sense to recognize the health problems and implement preventive programmes so as to maximise the potential of the youth to become a constructive force in the health developmental process of the country.

II Youth - Demographic Aspects

1. Age Range of Youth

The United Nations, for the purpose of International Youth Year (1985),defined youth as encompassing the age range of 15-24 years, which is the period of transition from adolescence to adulthood. The World Health Organization, noting that children in the age group 10-14 years are also in the adolescent pha se and therefore to be included in programmes for youth, suggested that the period 10-24 years be included under "youth". However , considering that 15-24 year olds have relatively more specific health needs, greater degree of freedom and discretion for health actions. it appears more appropriate to focus on this group, and at the same time to include the younger ages also where appropriate, in the preventive programmes.

2. Demographic trends

Approximately 18.2% of the population in India consists of youth (1981 Census). This proportion has been increasing in the last two decades concomi tant with the decline in infant and child mortality, and a less rapid decline in fertility. The proportion of youth would increase till about 2050 or so when the population is expected to stabilize(2). Assuming the present proportion of 18.2% youth population, the numbers of youth in India which was 125 million in 1981 is expected to be about 171.7 million in 1991 and futher to increase to about 189.85 million by the year 2001. Table 1 shows the increase in youth population since 1961 and projections for

1991 and 2001. Apart from the need for increased resources to cater to this large number of youth, it is also pertinent to recall that increasing numbers and proportion of aging population will also be laying competing claims on limited resources in the areas of health, maintenance of income, and housing. Thus, need based preventive and promotive health programmes to prevent chronic illness and disability among youth would be of critical importance to avoid a national situation of high dependency burden on the productive population.

3. Mortality Pattern

The mortality rates for youth are low compared with those for infants and children, and the aged. However, the cause of concern is that the causes of mortality in youth have shown a significant change, with a relative decline in deaths due to infectious disease and a rise in accident, suicide and unnatural causes of death. The cause of death statistics in India showed that the youth who accounted for 18.26% of the total population, accounted for 5% of all dea ths; 31.5% of youth deaths were accounted for by accidents and injuries, which was by far the most prominent cause of death(3). Among the female youth; the major cause of death was pregnancy and child-birth related (3). In fact, peak maternal mortality is in the age group of 15-24 years.

III The Context of Youth Health Problems

The specific health problems of youth stem from three major sources. One source relates to failure or delay or abnormality in the developmental process of maturation from a child to adult which involves the following components: (1 pp. 17-18)

(a) adaptation to the physiological and anatomical changes associated with puberty, and the integration of a mature sexuality into a personal model of behaviour;

(b) the progressive resolution of earlier forms of attachment to parents and family, and development, through peer relationships, of an enhanced capacity for interpersonal intimacy;

(c) the establishment of an individual indentity incorporating a sexual identity and adaptive social roles;

(d) the utilization of enriched intellectual competence with the acquisition of a sense of community and a world view;

(e) the development of potentials for occupational and leisure activities with a gradual commitment to those that are relevant to both the individual and the community.

The second source of youth health problems arises from the agressiveness and risk-taking behaviour innate to youth. The third source arises from special risks to reproductive health which arise due to developmental as well as social factors.

In the process of youth development, the successful achievement of the above mentioned components of youth development in a community, will depend upon, firstly, the resource and potential of the youth themselves to cope with these tasks in the given environment and emerge as healthy adults. Secondly, it will depend upon the economic and psychosocial health status, and security of the future of the community, since ultimately, these community characteristics will determine how far and in what directions the youth development would be facilitated. Majority of the youth health problems and undue risk-taking behaviour, overt and covert, could well nigh to be traced to frustration of one or other of these developmental tasks, or, to a general sense of insecurity and uncertainty about the future. The more the social norms and economic conditions restrict healthy maturation of youth or promote insecurity about the future, the more the incidence of youth problems. Thus, attempted suicide behaviour, risky sex behaviour, street and campus violence, substance abuse, have been found to be highest in poor urban areas where the environment is least conduc ive for growing youth. (1-p 56). These problems can largely be traced to imbalance between adolescent needs and resources to cope with the needs, in the prevailing social context.

Thus a major shift of emphasis is essential in the attempt to understand youth problems, from the conventional piecemeal approach to youth problems. There is need to shift to a holistic approach of comprehending the youth problems as arising from the interaction between normal adolescent developmental needs,the community's psychosocial and economic capabilities to meet the needs, and the youth's own psychosocial and mental health

resources to reconcile their needs with the available opportunities in the community.

IV Approaches to Youth Problems

Keeping in view the above concepts of the genesis of youth problems, the major approaches to youth problems would be threefold.

Firstly, to improve the resource capability of the youth themselves to cope better for their own health through education, counselling, and programmes for youth participation in health and socially constructive activities. Secondly, to promote a conducive community environment and family involvement in the process of youth development through promoting supportive, accepting and facilitating attitudes in communities and families. Thirdly, to develop a network of health, medical and social services (preferably integrated services from a single point), to deal with the major youth health problems when they arise, with the active involvement of youth in the services. These services would be required to provide at the minimum, reproductive health and treatment services; counselling and deaddiction services for substance abuse (tobacco, alcohol and narcotic drugs); accident, trauma and emergency care services; vocation/job counselling and liaison services to enable the youth to engage/employ themselves in socially or economically constructive activities.

V Major Youth Problems in India

The following are the major youth problems influencing the health status of the youth in India.

1. Unemployment

Unemployment particularly among youth is on the increase. The International Labour Organization estimated that in India, 67.2% of the youth were unemployed (and also not attending schools or colleges for education). Table-2 shows the increase in unemployment among youth between 1971-81.

Unemployment is known to be associated with high incidence of psychiatric disorders, depression accounting for 75% of cases (1). Youth, particularly those of lower socioeconomic status and those already vulnerable through mental disorder, are most affected by unemployment and recession. Suicidal behaviour is known to be

significantly high among the unemployed (1). Further this group constritutes a special challenge for preventive educational/ counselling out-reach services since they are readily available at a specific place in a group to reach out to (as the school goers or employed persons would be). While unemployment can cause disastrous personal consequences, the consequences of "educated unemployment among youth" can be of national urgency. The phenomenon of educated unemployment has been termed as "social dynamite"(4). The pre-dominance of the educated unemployed youth in the terrorist/seccessionist movements in Punjab, Assam, Bihar, and other areas, has been correlated by social researchers to the frustration of the unemployed youth, denied an opportunity to realize self-esteem through constructive activities(4).

2. Stress and Alienation

Youth of all socioeconomic classes, but paritcularly the urban poor, are prone to stress and alienation which influences their health behaviour in terms of smoking, alcohol and narcotic drug abuse, risky road behaviour, risky sex behaviour, suicide and violence. Youth are particularly prone to stress in the urban situation due to, relatively recent migration of parents to the towns leading to intergenerational culture clashes; loneliness, if youth migrate alone in search of employment (the age group of 15-24 is known to be highest among migrants); homelessness and pavement dwelling due to rapid urbanization without adequate housing; overcrowding, and lack of privacy; rootlessness and lack of family bondage in the urban setting. Tables 3 and 4 presents indices of the above stress and alienation-causing factors which are known to affect youth more profoundly than any other age group. The trends of household size (overcrowding), households per dwelling (homelessness), persons per dwelling (overcrowding) are presented in Table 3.

In Table 4, the percentage of migrants to total population in the major cities is presented. It may be noted that 55.94% of all migrants have been resident in the particular city for less than a year, indicating high proportion of recent migrants as well as frequent migration from place to place.

Stress from these sources is compounded by the stress due to

unemployment, stress of the educational system, insecurity of the future, and the growing aggressiveness and sex drive innate to adolescence.

3. Problems of reproductive health

The problems of reproductive helalth in youth are closely related to stress producing factors mentioned above, compounded by lack of awareness and education about biologically, socially and culturally safe sex behaviour. The following problems of reproductive health among youth are of concern.

(i) Teenaged Marriage and Pregnancies

The age at marriage in India is low, particularly in certain States and districts. The average age at marriage of females in India as a whole, was 18.3 (1981 Census) with a range of 16.1 in Rajasthan and 21.82 for Kerala (5). Going further, the proportion of females below 19 years who were already married (in the 1981 Census) was almost 50%, and infant 6.23% of girls below 14 years of age were married. Low age of marriage with resulting early fertility results in high maternal and infant risk, stoppage of opportunity for education, employment, proper physical and personal development. Particularly in India, it is not often realized that in the poorer communities, contrary to the developed countries, the period between 14-18 years is a period of active growth and maturation(23). An average rural girl or urban slum girl gains atleast five cm in height and upto seven kilograms in weight during this period. Marriage and childbirth terminates these processes due to competing nutritional needs, leading to permanently stunted, high risk mothers with a tendency to give birth to low birth weight babies during the rest of their reproductive lives.

The average age at marriage estimated country wide or State wide should not be taken at face value by administrators who need to be sensitive to local practices since local practices may vary widely from the State or the national average. For example in Tamil Nadu the mean age at marriage of females was 20•5 years (in 1981 Census), but in the urban slums of Madras, a study carried out in 1986 found it to be 14.7 years (5). Similarly for Karnataka State as a whole the mean age at marriage was 19.2 but in the districts of Gulbarga Division it was 15.2 (6).

With request to fertility in the risky age group of females below 19 years, the average number of children per female below 19 was 0.17 for India as a whole, with a rangeof 0.31 births per female in rural Andhra Pradesh and a low of 0.06 in Punjab and Kerala. Table 5 shows the mean age at marriage of females in the States of India and average number of births per woman below 19 years (5). The comparative risk of maternal deaths in different age groups, with and without antenatal care is indicated in Table-6.

Therefore, within the existing social mores, a major problem of female youth in urban and rural areas relates to the risk of teenaged marriages and pregnancy.

(ii) Unwanted Pregnancy and Illegitimacy

Pregnancy before marriage in youth and consequent resort to abortion - legal or illegal, the attendant risks of late abortion due to ignorance or embarassment of the youth, are all on the rise. Major hospitals and gynaecologists of almost all cities and large towns in India are reporting dramatic increase in the number of unmarried teenagers seeking abortion services(8). Statistics are not available, but it is anybody's guess how many illegal or septic abortions by quacks are carried out for every legal abortion by a trained practitioner, exposing these girls to the risk of infection, rupture of the uterus, chronic ill-health subsequent to septic abortion, subsequent infertility, risk of tubal pregnancy, etc. Quite apart from the physical health risks, the social and emotional consequences to the unmarried teenages are profound.

(iii) Sexually Transmitted Diseases (STD)

The full extent of the problem is difficult to judge because of under reporting. Rising trends of incidence of the two major STDs, syphilis and gonorrhoea have been reported from developed as well as developing countries. Estima- tes of the prevalence of syphilis and gonorrhoea in India by Sir John Megaw as far back as 1933 indicated a prevalence of 37 per thousand population. Present estimates indicate that one in every four STD affected persons in the world is an Indian.

The peak incidence of STD is known to be in the age group of 15-24 compared with other ages as reported from the USA (1 pp 65-66) and similar observations have been made from adhoc

surveys in developing countries. Sharp peak in hospitalization rates for acute pelvic inflammatory diseases (mostly due to go- norrhoea) has been noted in the age group of 20-24 years.(It has been estimated that 12-20% of females with untreated gonorrhoea will eventually develop salpingitis). These observations suggest that youth in India, and particularly urban youth are prone to sexually transmitted disease due to a combination of personal and social factors.

(iv) AIDS

The risk of AIDS in India is only just unfolding. Although at present AIDS cases and infections have been reported largely in older age groups, the emerging trends of AIDS in the north-eastern States suggest that AIDS would rapidly increase particularly in certain pockets. In Manipur, where an epidemic of narcotic drug abuse of injectable narcotics is widespread among the youth, sudden spurt in AIDS cases and infections have been noted in the last three to four years (9). More particularly, in the major metropolitan cities, where 31% of the urban population is concentrated(the 12 major cities) where continuous supply of injectable drugs is likely to be available), AIDS would emerge as a major problem of youth. Drug abuse, prostitution and blood donation are all closely linked phenomena and also closely linked to rapid urbanization, and all these factors promote the spread of AIDS. The cities and towns at high risk for AIDS transmission are the port cities which have very high floating population of Indian and foreign nationality; the urban population of Maharashtra also consititutes a high risk population due to concentration of population, which accounts for almost 40% of the urban population of India. Increase in AIDS is being reported almost all States in India.

A major risk factor for AIDS which is emerging in India is increasing incidence of homosexuality among youth in cities. This phenomenan has been highlighted by a study in the Ahmedabad General Hospital which reported that every month atleast 70 cases of youth with sexually transmitted disease due to homosexuality, mostly hotel boys, beggars and youth living in hotels, were treated (10). Homosexuality is a major risk factor for AIDS.

Thus overall, the risk of AIDS due to risky sex behaviour among youth is emerging as a major threat to health and survival.

(v) Prostitution of adolescents

Prostitution of adolescents is rapidly on the rise and will increase with further rapid urbanization expected by 2000. Child prostitution of girls and boys has been in the rise. It has been estimated that 20% of the estimated two million prostitutes in India are minors below the age of 18 and the proportion would increase (11). Prostitution of young boys has been reported from many large cities particularly Surat and Ahmedabad(10), and most probably significant problems in other business centres and port cities of the country.

4. Health Problems due to Substance Abuse.

Substance abuse, namely, smoking and non-smoked tobacco use, alcohol abuse, narcotic drug abuse is particularly likely among the young for many reasons. Most of the youth are unaware of the addic tive nature and dangers of these substances when they start the habit, particularly the children below 15-18 years. Apart from this factor, the other factors predisposing to the risk are the innate risk taking behaviour in adolescents; craving for experience; need for peer acceptance and identity which can be achieved through imitation of behaviours; low self-esteem characteristic of the adolescent phase of life; high levels of frustration and unemployment; rootlessness and alienation of urban life. Keeping in view these largely environmental factors in the promotion of drug and substance abuse by children and youth, it is heartening to note that the ultimate risk of becoming dependent on these drugs upto ruination, greatly depends upon the family care and love, and community support to handle the problem. It has been observed that children who grow up with low self-esteem and lack of the three As, Attention Acceptance and Affection, are at high risk of becoming drug or alcohol addicts, as comapred with those who grow up in an atmosphere of love and concern. (12,13,14).

(i) Smoking and Tobacco Use

Smoking and tobacco use are among the most widespread problems cutting across rural - urban and socioeconomic lines. The family and community permissiveness and tolerance is no doubt the major reason for such widespreard tobacco use. Smoking and chewing tobacco during youth may not immediately lead to health problems, but it is of serious importance, since it is

established that almost 80% of adult smokers get addicted during their teens (15). Smokers are ten times as likely before to die before the age of 60 as non-smokers; due to cardiovascular causes and cancer. A recent estimate in India put the proportion of smokers population of India at 50% of adult males, and tobacco chewers at 10% in both sexes (16). Among the young the prevalence of smoking is likely to be around 10% among males(1). Thus, towards prevention of premature death in the adult population, programmes for prevention of smoking and tobacco use among youth are required.

(ii) Alcohol Abuse

During the last two decades and particularly in the last four to five years, India has witnessed a tremendous increase in the availability and consumption of alcohol in the cities and villages alike. The increased availability and permissiveness for alcohol use by families, peer groups and the community as a whole, both in rural and urban areas, is a major factor contributing to the spread of alcoholism, progressively younger ages of getting initiated to alcohol, and frank alcoholism among younger and younger age groups. These factors, combined with the stress of growing urbanization have resulted in high alcohol consumption by adolescents, cutting across socioeconomic lines. Alcohol consumption, in the short term results in increased incidence of accidents, street violence and domestic violence. In the long term, alcohol consumption in adolescence is associated with high prevalence of alcoholism in adults leading to low productivity, and, premature mortality due to cirrhosis of liver, peptic ulcer, malnutrition, psychiatric disorders, accidents, certain types of cancer, and cardiac disease(1). This would generate high dependency ratio in the population. Besides, it has been estimated that in India alone, about 4000 crores is lost annually to the nation due to sickness absenteeism in industry which is another aphorism for alcoholic absenteeism(17).

While the curtailment in alcohol availability should be a long term goal for curbing alcohol consumption, certain observations regarding personality types who run the risk of becoming alcoholics, would be useful for helping such youth to avoid alcohol. It is known that stressed or depressed personality, immature personality with low self-esteem who experienced severe domination in childhood, predispose a person to become

alcoholic. Special counselling services, youth education and community strategies can be devised to enable such individuals to abstain from experimenting with alcohol.

(iii) Narcotic Drug Abuse

Drug abuse among the young is sharply on the rise. Contrary to popular belief, drug abuse is not confined to urban youth. The comparatively easy availability of drugs in the metropolitan cities has increased the prevalence in these cities. However, other parts of India are not free, and those with a tradition of drug use by adults are experiencing a surge in drug abuse, especially by unemployed youth and adolescents. The North-East is known to have a tradition of charas and ganja, a situation which is being worsened by injectable hard drugs smuggled across the international borders. Charas and ganja are similarly prevalent in rural and urban Bihar as well as eastern Uttar Pradesh. Kashmir has a tradition of opium use. The major geographical areas of use of injectable drugs (which predispose to AIDS, Serum hepatitis, rapid deteriorat- ion and death) are Tamil Nadu, Kerala and now, growing menacingly in the North Eastern States of Manipur, Mizoram, Tripura and others(18).

Considering the economic and health consequences of the milder narcotics (charas, ganja and bhang), it is known that these drugs result in far smaller drain in resources (approximately Rs.10/- per day compared to Rs.35-40 a day for a brown sugar or heroin addict). Health consequences and loss of productivity are also less- addicts of the former can remain productive and active even after 30 years of addiction whereas the addicts of hard drugs become very sick and suffer physical breakdown within six months to a year. A major observation of significance by SPARC, a voluntary organization working with youth problems, was that 60% of all drug users are from the poorer classes. Further the surv- ey which covered nine cities showed that only 14 percent of the drug addicts and potential addicts were students; the rest were school dropouts, unemployed and partially employed(18).

Experimentation with drugs by teenagers has been found to be the beginning of the road to addiction. In the middle and affluent classes, use of drugs may be perceived by adolescents as the means to gain peer acceptance and to gain a sense of identity (which are both natural quests of the adolescent). In the poorer classes, narcotic drug use is introduced to the uninitiated as a

means to escape the stresses of poverty. Although large number of teenagers do experiment with drugs, only a few become addicts'. A study in Chandigarh found that 7.7 percent of sampled non student youth, had tried drugs at some time in life (cannabis, amphetamines and opium); in Islamabad 100% of non student youth in the sample, had tried drugs and continued to use them on and off; in Penang 9.8% had experimented with drugs and in Toronto almost 93% of youth had experimented with drugs(1).

It is now increasingly recognized, that while the risk of initial experimentation with drugs cannot be fully gaurded against, the prevention of subsequent addiction and motivation for deaddiction (which is the key to deaddiction), depends on three factors: promoting the three As in the family context, Attention, Affection and Acceptance; law enforcement; and, counselling of children to resist peer group pressure in the social context (12,13,14).

5. Accidents

As discussed under section III, the age group of youth is maximally prone to accidents and accident deaths due to the innate risk-taking behaviour which results largely from the adolescent hormonal surge, peer imitation and need for esteem through self assertion. A certain amount of aggressive behaviour is a natural and healthy part of development, but excessive indulgence in risk-taking is often an expression of thwarted self esteem or frustration, leading to suicidal risk-taking.

In India, accidents assume particular importance. The number of fatalities due to road accidents went up tenfold during the period 1960-1990, and 22% of those killed were youth aged 15-24(19,3). Of approximately 1.4 lakh deaths expected and 14 lakh expected to be handicapped annually by 2000 due to accide- nts, the peak incidence will be among youth(20). Youth are more likely to be involved in accidents while riding bicyles and motorised two wheelers which prdisposes to fatalities(19). For every child or adolescent killed in an accident, another is permanently handicapped, and ten temporarily handicapped requir ing speciality services for hospital treatment and rehabilitation. Keeping in view certain factors beyond control, such as poor maintenance of roads, increasing vehicle load on the roads, tightening public funds for road maintenance, the factors which are within control to avoid road fatalities and accidents are, to improve driving and road

behaviour through education, and to reduce risky driving pariticularly by youth, through effective legislation and enforcement(19).

6. Suicide

About 50,000 suicides are registered in India every year. An indeterminate number of suicide deaths in rural areas are not registered at all, and another substantial number are registered as accidental deaths. Forty percent of suicidal deaths have been found to belong to the age group of 18-30. Thus about 15000 to 20000 completed suicides occur every year among youth, with an estimated 15-20 lakh attempted suicides, (for every completed suicides it is estimated that there would have been about 100 attempted cases. Among the States, owing to a combination of reasons Kerala is particularly prone to suicides with a rate of 22.07 per lakh population per year compared with 7.03 per lakh for the country as a whole. The major causes are educated unemployment, dowry deaths, and social complications of the exodus to the Gulf for employment.

Psychiatrists in all major cities agree that the suicides especially in the young in the cities are rapidly on the rise. The major force promoting this phenomenon is rapid urbanization leading to breakdown of the extended family structure, lack of time spared by adults for youth to listen with a sympathetic ear to the tensions and problems. The major youth problems relate to educational and career tensions, love affairs, self esteem problems due to perceived physical or sexual abnormality and dowry problems. One also observes that a fundamental cause of these tensions can be traced to, the tendency of adults to try to achieve self-esteem through the childrens' performance, thereby pressurising for education and career performance, dowry etc. Thus, the major cities lead in suicide and parasuicide rate. Madras has a suicide rate of 21.65 suicide per lakh population. Bangalore the fastest growing city has a rate of about 15 per lakh(26). Children as young as 10 or 11 are reported to be committing suicide. The silver lining to the dark picture is that, majority of the suicides can be prevented by an understanding attitude and counselling from the family or friends. Basically this requires a change of attitude of families from a judgemental, alienating approach, to that of nonjudgemental, caring attitude about the person rather than his/her performance and economic potential(26).

7. Crime and Violence

Once again the complex factors of rapid urbanization, poverty, population explosion,educated unemployment, and increasingly violent depictions in the mass media-films and television, have given rise to increased crime and violence. The large scale drafting of the educated unemployed youth for secessionist/violent student movements in the States of Punjab, Assam, Bihar, etc., is well known. In the major cities pariticularly the metropolitan cities, increasing involvement of the youth in crime is being reported. The police department of Bombay reported marked increase in crime rate in recent years, and that, about 60-80 percent of crimes were committed by youth in the age group 18-22 years, many of them belonging to the affluent class. These disturbing trends underline the complex issues of youth violence which cannot be entirely attributed to simplistic factors like poverty or unemployment alone.

8. Occupational Health problems

Occupational health problems tend to be higher in working children and youth due to several reasons. Firstly, hazardous industries prone to cause chemical damage or fire hazard prefer to employ children and youth for profitability as well as to avoid legal problems in case of accidents. Secondly, children and adolescents work on machinery designed for full grown adults which results in undue fatigue and proneness to accidents due to ergonomic reasons and also for lack of adequate sense of responsibility in childhood.

The Child Labour Act 1986 stipulates that no child can be employed in industry. As a result, in the organized sector of industry no child is employed. However 17-20 million children (under 18) are estimated to be working in the unorganized and domestic industries as well as agriculture. An estimated five lakh children are working in hazardous industries. The hazardous industries still heavily dependent on child labour are, the match industry of Sivakasi in Tamil Nadu, the gem polishing industry in Jaipur, the slate pencil industry in parts of Madhya Pradesh and Andhra Pradesh, the brass industry in Moradabad, Carpet industry in Mirzapur, pottery industry in Khurja, glass industry in Ferozabad, and the lock industry in Aligarh. Further the numbers of children in these industries is increasing inspite of the Child Labour Act of 1986. The number of children under 14 working in the match

industry in Sivakasi increased from 17,000 in 1988 to 20,000 in 1990; in the carpet industry of Mirzapur, it increased from 20,000 in 1985 to 60,000 in 1990(22). The complex problem of child and youth labour in industry and particularly the health hazardous industries, would result in millions of sick and handicapped youth and adults in India by 2000 and beyond young girls working in cramped places in a sitting position for long hours, e.g. bidi making are prone to develop deformed pelvis, difficult labour and high maternal risk in later life.

9. Nutrition-Related Problems

The incidence of undernutrition among adolescents is high in India with almost half the population living below the poverty line. Malnutrition causes stunting of growth but more particularly is of significance in females because the adolescent period even beyond 14 upto 18 years is the period of maximum growth of height and pelvic growth which is critical for the subsequent maternal role. Malnutrition in females is aggravated by the competing demand of there productive role in case pregnancy supervenes(23).

V. Policies and Programmes for Health of the Youth

Keeping in view the above perspectives of youth problems, three major approaches to promote health of the youth, are possible. To recapitulate, firstly to devise specific programmes and infrastructure to meet his/her developmental needs within the existing social framework, without endangering his/ her present and future health. This approach would focus more on mass and group educative as well as counselling programmes to assist in healthy mental and emotional development through promotion of self-understanding by youth and thereby adopt healthy adaptational pracitices. Also, this approach would involve, as an extension of the educative programmes, programmes to pomote healthy outlets for adolescent energy as appropriate to the age and and socioeconomic needs-namely, promotion of sports, healthy leisure activities, vocational training, promotion of entrepreneurship, involvement of youth in socially constructive activities, involvement of youth on a large scale in the counselling and health ser vices for youth themselves, etc.

The second approach which is a much more long term measure, is to gradually improve the family and community involvement in the process of youth development and health promotion through.

(a) suitable legislation and enforcement to minimise the involvement of youth in hazardous actions(smoking and tobacco, alcohol and drug abuse, accidents and industrial hazards, age of marriage,etc).

(b) education for developing the attitudes of the three As(Attention, Acceptance and Affection) in families and communities which is the key for healthy youth development. Quite likely, this change would take long to be brought about, possibly when few generations of youth are educated and better initiated to the practices of mental and psychosocial hygiene, who would grow up to form the influential adult component of the community of the future.

The third approach involves creation of integrated health, medical and social services to provide reproductive medical and counselling services; counselling and deaddiction services for alcohol, drug abuse and smoking (tobacco use) behaviour; accident, trauma and emergency care services; vocational/entre-preneurial/ job counselling; liaison services for employment (including organiz ed and unorganized sector); liaison services to enable youth to engage/employ themselves in sports or economically/socially constructive activities, according to their need.

These approaches are complementary to each other and need to be developed if we are to meet the needs of youth on a short and long term basis, in the best interest of the youth and of the country. The first and second approaches are largely primary preventive approaches to youth problems. The third involves planning for infrastructre to deal with health problems when they arise, prevent future recurrence of the health problem, as well as provide alternatives to the affected youth to get socially and occupationally rehabilitated subsequ ent to a misadventure.

Fundamental to the success and economic feasibility of all three approaches would be, a recognition that youth and youth organizations already existing are themselves the greatest resource for youth health programmes. The utilization of youth and youth organizations have been recognised across the world,as the key to promoting acceptability of programmes to youth, as well as for economic feasibility of programmes envisaging wide out-reach

(school and college goers; full-time and marginal child and youth workers; unemployed school dropouts).

Having identified the major aproaches to strengthen the youths' resources and the community resources, the specific programmes for prevention and management of each of the major categories of health problems are discussed in the following paragraphs.

(a) Programmes for Promotion of Reproductive Health

A major aspect of programmes for promotion of reproductive health should include measures to educate the community against child marriage of minors as well as strict enforcement. Apart from this problem, the problems of reproductive health among youth are partly attributable to social taboos and societal ignorance of the need for contraception education and sex education to adolescents and youth. This results in unhealthy or unsafe handling of the sexual drive, ignorance or reluctance to avail reproductive health services. This situation is compounded by unfavourable attitudes of health service staff to provide the requisite contraceptive, medical and counselling services to unmarried youth. As a result, there is further aggravation of the problem, for example, a male or female youth who has contracted a sexually transmitted disease avoids seeking treatment, resulting in long term complications; an unmarried teenager avoids seeking contraception or early abortion services and thereby renders the late abortion much more hazardous since she would anyway require to have the pr egnancy terminated; recource to quack or illegal abortions to avoid unfavourable publicity and attitudes of the organized health service.

Therefore a major programme essential for promotion of reproductive heal th of youth should include an adequate education programme for the youth; and orientation of the health service staff to willingly provide counselling as well anti STD, contraception and abortion services to youth(whether married or unmarried), and obstetric serivices particularly sensitive to the problems of teenaged pregnant mothers.

The youth education programme should systematically cover

school and college students through a formal programme, and attempt to cover employed and unemployed youth through

services at the workspots, at youth centres attached to the health posts or located in the community, sports centres, etc. To provide such services in a systematic manner, the health and juvenile welfare services could be integrated, and the staff (particularly professionally trained health educators and social workers) oriented to specifically reach out educative and counselling services to the young in a given geographical area. The focus of education and counselling should be on enabling youth(and adolesents below 15) to comprehend the following:

- Physical, emotional and social development of self; - sexual maturation;- sexual drives and behaviour - human reproduction;- sexuality in the context of relationships; - sexual preferences; - fertility regulation; and, sexually transmitted disease.

Combined with staff of the health and social welfare services, local youth workers and students could be trained to provide counselling and informal education on a voluntary basis at the youth/health/integrated centre during fixed convenient hours when the youth could avail the services from them. It has been found that peer counselling is more acceptable and effective.

(b) Programmes for Promoting Mental Health, and Rehabilitation

Towards prevention of the problems of substance abuse (alcohol, smoking and tobacco use and narcotic drugs), accident - proneness, crime and violence and suicide behaviour, a systematic programme is essential, combining educative aspects of self development and self acceptance, and harmful effects of these behaviour, with liaison services to assist the youth in finding healthy outlets for the basic drives of youth-namely liaison to put them in touch with sports, vocational training, employment in the formal/informal unorganized sectors, promotion of entrepeneurship, voluntary work for youth or social deve- lopment, etc. Together with these services, a framework for basic deaddiction services(incorporating counselling as well as chemical deaddiction) needs to be developed and implemented, possibly, through integrated health and juvenile service posts.

These services in themselves cannot be very effective unless effective legislative measures to curb the availability of tobacco products, alcohol for adolescents (atleast those below 18 years of age), and narcotic drugs, are passed and enforced, restriction of

smoking and alcohol even by adults in public places, ban on advertising of these products by the media or display boards,and promotion of non-smoking ethos through opinion leaders such as sports and political personalities.

Needless to say, health and social welfare services can achieve little in isolation unless a comprehensive plan is chalked out ot provide a supportive network of services such as vocational training, recreational centres, employment, an information system to link the users with the facilities, and much needed co-ordination between the sectors.

(c) Examples of Experimental Approaches Tried in Other Countries

Many successful experiments of integrated health and counselling services with the active participation of the youth have been made in developed and developing countries. In Nigeria, under the National Youth Service Crops programme, all graduates and postgraduates of universities (professional as well as non-professional) are required to serve the nation for one year after graduation. The Women's Centre Project for Adolescent Mothers if Jamaica has succeeded in rehabilitating large number of pregnant school goers for the future, socially and educationally. "The Door - A Centre for Alternaitives" became a model to demonstrate the effectiveness of comprehensive integrated serivices and linkages between existing service systems,providing services ranging from counselling and rehabilitation for drug addicts, reproductive health services, to occupational rehabilitation. Similarly the Adolescent Orientation Centre (CORA) in Mexico City, the Co-operative School for Adolescent Mothers in Durham, North Carolina, the Regina Multiservices Centre for Youth in Canada, the work of the Girl Guides of Upper Volta, Canada and Zambia, are but few exa- mples of such efforts(1)

VI Presently Available Programmes for Youth Development in India

Recognizing the immense potential of youth in the process of national con- struction and development, the Government of India has launched several progra- mmes aiming to involve college students in the process of national development (27).

1. The National Service Scheme

The earliest scheme was the National Service Scheme started in 1969 with a coverage of about 40,000 students and expanded to 7.5 laks students in 1985 co- vering almost all univerisities and more than 3500 colleges. Under the NSS st- udents have been involved during vacation period in rural development and cons- truction work and in urban slums.

The encouraging features of this scheme are, the wide coverage of stude- nts, by and large positive experiences associated with the NSS by youth, and the fact that almost half the enrolled youth volunters of NSS actually partic- ipate in the camping programmes organized under the theme "Youth for Rural De- velopment". The limitations of the scheme have been that enrolment has been more or less on adhoc basis wihout any systematic drive to involve youth in the scheme, and sporadic nature of acitivities (only during vacations) which leads to loss of motivation of the students. Another major limitation of the NSS is the focus on utilization of youth for social development, rather than the theme of social development activities for youth development and mental health. This change of focus can lead to a new perception and implementation of NSS and also greater acceptability and motivation for students and teachers to enroll in the NSS.

2. Nehru Yuvak Kendras

The scheme of Nehru Yuvak Kendra was started in 1972 with a view to serve the non-student and rural youth to improve their personality and employability by programmes to improve social skills, leadership training, vocational training,etc. Mostly youth volunters are attached to the NYKs. The NYKs have been able to train youth in locally relevant technology and skills such as biogas plant construction and maintenance, bee keeping, smokeless chulhas, road and community hall constructions, etc. TRYSEM (Training Rural Youth for self-employ ment) has been implemented by the NYKs. Starting with about 30 NYKs in 1972, there are about 200 functioning now in the country.

3. Scout and Guide Associations

Scout and guide associations involve youth towards promoting balanced phys ical and mental development.

Several other sporadic activities have been undertaken for promotion of na tional integration through exchange visits of youth, construction of youth hostels to promote youth travel and sports. A major scheme for employment, the Nehru Rozgar Yojana was launched in 1989 and is being implemented chiefly as an em ployment creation scheme.

VII Future Directions of Youth Programmes and Policies in India

The changing youth scenario as presented in the paper suggests that the pressing needs and problems of youth are taking on newer and newer dimensions with each passing decade, particularly in India. Youth problem was largely summarized in one word in the decade of the fifties, namely unemployment. In the sixties, to unemployment was added the growing stress of alienation associated with massive urbanization. A fresh generation of problems appears to have emerged in the seventies due to superadded westernization and new forces in the seventies, the problems of smoking, alcohol and drug abuse; newer significant problems emerged in the eighties concomitant with increased social pressures as well as freedom and technology to express frustration and self identity - the overwhelming problems now are the campus and terrorist violence,suicide risky sex behaviour, accidents, and crime. The youth schemes launched in the sixties and seventies were chiefly conceived to tackle problems of idleness (rather than unemployment), and characterised by sporadic rather than programme based activity. They are thus,in their present form, too limited to address the real need.

Keeping in view the changing profile of youth problems and the documented success of integrated, participatory approaches to youth problems in many countries, as illustrated above, there is urgent need to develop a national policy on youth and to implement comprehensive programmes for youth development. Given the established acceptability and sound basis of most of the currently

operating youth schemes, these schemes if systematically expanded to ensure maximum coverage, could contribute much more to youth development in India, provided these are networked into a holistic approach to youth problems.

ISHA hopes that this Conference would serve as a catalyst to create awareness of the immense potential of youth as well as their critical needs, which should be sincerely addressed even though the initial efforts may be amateurish and experimental. Beginnings have been made in many countries including India. The task now is, to match the efforts to the needs, and particularly to launch intersectoral, interdisciplinary efforts with the active participation of the youth themselves.

VIII Conclusion

In conclusion, the youth in India are faced with a wide range of health and socioeconomic problems which seriously threatens their physical, mental and social well being. Rapid urbanization, industrialization,westernization of values and aspirations, and politicalization have combined with the pressures of unprecedented population explosion resulting in tight sqeeze of opportunities and options available to youth, with the consequent frustration. Poverty, Unemployment, homelessness and overcrowding, influence of unrealistic mass media, are adding their weight to the innate developmental stresses of youth, and thereby, distorting the youths capacity to mature into physically and mentally healthy, productive adults. Youth in general are at increased risk due to problem of sexual and reproductive health risk, aggressiveness and risk-taking behaviour, craving for new experiences, which are a part of the normal psycho-socio- sexual developmental process. Part of the risk is also due to low awareness and concern for the consequences of these bahaviours. The health risk is howev er compounded greatly by the compelling socio-cultural-demographic realities around them. This has given rise to high rates of substance abuse (smoking, alcohol and drug abuse), risky sex behaviour (leading to sexually transmitted disease, AIDS, teenage pregnancy within and outside marriage, legal and illegal/septic abortions); suicide and parasuicide behaviours; street and campus violence; prostitution of adolescents; and, accidents.

Thus, comprehensive psycho-socio-health approaches are required with the active involvement of the youth to tackle the problems of youth. Examples of innovative integrated approaches

are available from several countries. Within India we have large number of youth organizations which offer tremendous potential for youth involvement in building up a psychocultural ethos for a healthy youth and healthy society.

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Table - 1
Demographic Trends in Proportion of Youth Population in India
1961-2001

Year	Youth Population in million	% of total
1961	73	16.69
1971	90.6	16.52
1981	125.1	18.26
1991 *	171.7	20.5
2001 *	189.85	19.25

* Projected

Source:

1) Government of India/WHO Coordination Committee - Country Health Profile - India, New Delhi, May 1989

2) Family Welfare Programme Year Book 1986-87, Government of India, Pp. 59-61

Table -2
Work Participation Rates by Youth - Main Workers by age and sex

Age Group	Males		Females	
	1971	1981	1971	1981
15 - 19	55.2	51.0	15.78	18.46
20 - 24	81.43	76.89	18.12	20.39

Total unemployed in 1981 (ILO estimates) of both sexes : 67.2%

Source: Country Health Profile - India GOI/WHO, May 1989

Table - 3

Indices of Homelessness and Overcrowding
Household Size, Households per Dwelling and persons per Dwelling
(India - 1981 Census)

	1961	1971	1981
Household Size			
Rural	5.2	5.6	5.6
Urban	5.1	5.5	5.5
Total	5.2	5.6	5.6
Households per dwelling			
Rural	1.05	1.05	1.08
Urban	1.06	1.03	1.05
Total	1.05	1.04	1.07
Persons per dwelling			
Rural	5.53	5.89	6.06
Urban	5.63	5.89	5.74
Total	5.54	5.89	5.90

Source: Country Health Profile - India GOI/WHO, May 1989

Table - 4

Indices of Stress and Alienation - Migration

Percentage of Migrants - Major Cities of India (1981 Census)

City/Urban		% of migrants to total population		Reasons for migration % of total migrants	
		Male	Female	Empl. Male	Marriage female
1.	Calcutta	32.78	29.37	43.02	33.03
2.	Greater Bombay	54.60	47.40	61.69	36.69
3.	Delhi	45.09	43.91	50.51	29.64
4.	Madras	34.09	34.87	50.22	38.53
5.	Bangalore	37.78	37.45	50.72	37.50
6.	Ahmedabad	36.81	39.06	49.43	43.29
7.	Hyderabad	19.59	20.29	43.65	31.33
8.	Pune	47.24	49.71	42.35	43.94
9.	Kanpur	28.39	30.55	49.54	55.01
10.	Nagpur	32.82	37.18	33.82	46.94
11.	Jaipur	31.21	34.42	51.67	46.46
12.	Lucknow	26.53	28.54	45.76	47.91

Table - 5

Mean Age at Marriage of Females and Average number of births per female below 19 years in States of India (1981 Census)

Sl.No.	State	Mean age at marriage of females	Average number of livebirths per woman below 19 years
1.	Andhra Pradesh	17.6	0.28
2.	Bihar	16.55	0.23
3.	Gujarat	19.52	0.07
4.	Haryana	17.84	0.15
5.	Karnataka	19.21	0.2
6.	Kerala	21.82	0.06
7.	Madhya Pradesh	16.56	0.24
8.	Maharashtra	18.77	0.16
10.	Punjab	21.07	0.06
11.	Rajasthan	16.10	0.18
12.	Tamil Nadu	20.25	0.11
13.	Uttar Pradesh	16.71	0.19
14.	West Bengal	19.23	0.22
	All India	18.33	0.17

Table - 6

Maternal death rates as related to age group and antenatal care

Maternal Age (Years)	Death Rate (per 1000 births)	
	Antenatal Care +	No Antenatal Care
<15	5	42
15	0	58
16	0	18
17 - 19	1	21
20 - 24	1	14
25 - 29	2	28
25 - 29	1	28
> 30	2	18
All ages	1	24

Source: WHO, Young People's Health - a challenge for Society, WHO, TRS 731,1986

5. MENTAL HEALTH OF THE YOUTH

- Keynote Address

*M. Papakumari**

I Introduction

Youth is between childhood and maturity (15-26 years), physical growth, endocrine changes, sexual development and urges disturb the adolescent. Physically he is well grown, but emotionally his personality is still developing and identity is seeking a firm terrain. In an atmosphere rigid with cultural taboos, social restrictions and orthodoxy it is difficult for the youngster to grow up without disturbances. It is equally difficult in a culture in transition with change in family systems and exposure to conflicting views. In a liberated permissive society without constraints, the youth struggles and faces problems more often than not.

II Mental Health of the Youth

The end of childhood and the requirements for adulthood are not clearly defined, which adds to the confused struggle which the youth undergo before attaining the status of independent adulthood. This is a period of intensified preparation for the forthcoming role of young adulthood. In both the developing and developed countries, the prolonged period of education required for specialised occupational roles, consequent delay in becoming independent and delay in marriage makes the life of the youth very stressful.

The youth are very sensitive to the opinion of the peer group. Girls enter puberty about two years earlier than boys and may be disturbed by sexual thoughts and desires leading to the problem of teenaged pregnancy. The girl who is depressed and unhappy, insecure and doubtful about her attractiveness, or if she is from divorced parents from a disturbed, unstable home, is more likely to go astray than one from a happy, stable home.

In general, sexual thoughts of both the girls and boys are repressed and directed outwards as teenage crushes, hero worship and idealisation of movie, music, sports and other and idealisation

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of movie, music, sports and other popular personalities.

Sex drive is at its peak, especially for boys between 17 and 19 years of age. The youth's interest gradually shifts out of the house. Home is only a base. The real world for him is outside home and the most important relationships are with those of similar ages and interests (peer group) the group varies for each individual. A core group exists, made up of a few sustained and emotionally significant friendships, in addition to a number of other contacts who may come and go and are of lesser importance to the adolescent. They have their distinctive jokes, phrases and unique ways of dressing and thinking.

Piaget points out that adolescents are capable of showing remarkable creativity. Thinking is abstract, conceptional logical and future oriented. They show interest in poetry, music, writing, art and other forms of creativity, possibly for the only period in their lives. In the majority, these interests disappear as mental maturity sets in. Physical growth and sexual development are at its peak; preoccupations with body image and male-female roles are of main concern during this stage. Sexual experimentation could lead to problems. In the developed countries, 80% of the males and 70% of females do have sexual experience by the age of 19 years.

Thinking is no longer limited to the concrete environment but is concerned with the larger world and future. Humanitarian issues, morals, ethics, religion, and judgement interest the youngsters. Ethical principles and codes of conduct get crystallised. There is a gradual transition from dependency to independence, Negativisim is a common behaviour of the youth which is meant to show others that they have a mind of their own. This characteristic often leads to never-ending arguments at home and outside. Members of each generation can recall how clothes, hair styles, and other interests were used to show parents that they had minds of their own.

By young adulthood, the super-ego or conscience is established depending on one's experience. But all through life, one's Super-Ego has to be able to change and develop in order to accommodate new life situations. The family's role is important by offering support and encouragement to help the youngster to emerge as a mature adult. With a healthy identity, when individual has role confusion it may manifest with behavioral problems,such as running away, criminality, taking to drugs and alcohol or even overt psychosis. He may join various cults and unhealthy groups.

The pressure by parents, peers and others as well as from within, confuse in deciding about a vocation. What one wants and what can be achieved, may be entirely different, leading to a unsatisfactory vocational identity. The youth has to be helped to set goals which could be reached in order to develop a sense of competence. Vocational guidance and counselling would be helpful.

In early adulthood, an adult role is taken over. The youth may leave home and functions more independently. Relationships with the opposite sex partners are more interesting and serious. The twenties are spent for the most part exploring options for occupation and marriage. The choices made in the teens and early twenties may be recognised to be false and improper starts, and serious thought is given to pracitical aspects. (breaking of love affairs), social class, gender and culture determine the choice of a particular occupation. For women, choice is between work and family; work being primary and family being secondary, or absent, or family being primary and work being secondary or absent. The second is chosen by the majority. Women take care of the home, children and also deal with a suitable career. Men are not expected to consider the role of husband, father, and the worker. Men are more concerned with career and advancement and young women, more with their family roles.

Dual career families in which both husband and wife work, are becoming more and more common. When the family-oriented needs, such as, suitable wor king hours, leave, shared jobs and part time jobs are recognised, the family stress could be minimal. Every youth in his twenties starts with hopes of become successful. A healthy adaptation to work, satisfactory relationship with colleagues and job satisfaction all together increase the self esteem. Job dis-satisfaction leads to a high rate of job changing, absenteeism and being troublesome at the work spot.

Unemployment affects the economic needs as well as psychologically. Incidence of alcoholism, violence, drug abuse, criminal behaviour, suicides and mental illness is more in the unemployed.

Success or failure in life depends on how well the ground work has been laid during early childhood, and how well the young adult interacts with the environment (Erickson).

The intimacy of marriage, friendship, and other relationships are all accepted smoothly in a individual with a resolved indentity. In contrast, the person who has role confusion is left without friends and marriage partner and he become self absorbed and self indulgent, accompanied by a sense of isolation.

In true love there is mutuality. During childhood, it is with the parents,and then with friends, and in the young adult it is with the marriage partner.

Summary

The above summarizes the major factors influencing mental health of the youth. In summary, role clarification of self in one's social, family and economic roles, accompanied by commensurate emotional maturity and vocational skills, results in well-adjusted personality whereas confused self-identify or emotional immaturity/poorly developed skills of employment, results in maladjusted youth, prone to mental health problems.

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6. DIMENSIONS AND DISCRIMINATION IN HEALTH CARE FOR BOYS AND GIRLS

A Lalitha and U.R.Kaliappan***

I Introduction

For centuries in India, the birth of a son has been deemed the gift of God and the birth of a daughter has been deemed at best a disappointment. The rejection of unwanted girl can begin even before her birth. Born into indifference and reared on neglect the girl child is caught in a web of cultural practices and prejudices. In the traditional societies, birth of a girl is usually viewed as a burden and liability and sons are considered ritually and economically desirable.

II Study Objectives and Methodology

Towards studying sex discrimination to the girl child especially with regard to health care, a study was conducted at Vellore,15 km from Coimbatore. The total population of this village is around 27,000, consisting mainly of landless agricultural labourers and landowners. Data was collected by interviewing mothers' from the landless labourers and landowners. Most of the respondents' husbands work in the industry for the subsidiary income, due to inadequate rainfall in the village. Approximately 130 land owning families in the village and the remaining landless labourer families and other categories form the study population. The village does not have any Government Primary Health Centre. Instead, there is an Employer Welfare Trust organized for mill workers and another Welfare Centre,The Kin Round Table - 20. Five Clinic Centres are run by medical practitioners in this village.

The sample size is 150, 75 families each of landless labourers and landowners with atleast one male and one female child. The patterns of health care and child care were investigated including aspects such as, breast feeding, frequency of breast feeding per day, type of medical treatment for illness,time lapse before care

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initiated, number of consulations and duration of treatment. Regularily of meals fed to children was also explored.

III Results

1. Breast Feeding

Data analysis from this study showed that overall, the practice of breast feeding continued for a longer period among landowners as compared with landless labourers. The reason was that landless labourers worked in the fields throughout the day, and also the poor nutritional content of their food forced them to stop breast feeding at an early stage. But, in a very small percentage of of landless labourers families, girls were breast fed for shorter period than boys. This was reported to be because of the desire to conceive soon so that they may have a son after a daughter's birth. It was also found that majority of landless labourers and landowners did not show any discrimination in sex with regard to breast feeding, which shows that economic factor does not affect the female child in terms of breast feeding. With regard to frequency of breast feeding there was no discrimination between landowners and lan dless labourers in either sex.

2. Health Care During Illness

With regard to nature of illness, fever, cold and diarrhoea, were the major illnesses among children. The type of treatment among landless labourers, depicted that greater proportion of girl children were taken to the native practitioners before consulting a modern qualified physician. This proportion was more than of the male children. Whereas, the percentage of male children given allopathic treatment for their illness was greater than that of the female children. In the landowner's family, there was no discrimination shown in type of the treatment given.

Thus, discrimination in type of treatment given to female children prevailed only among landless labourers who were economically weak and educationally lagging. Which may manifest their values and priorities.

In both the groups, the male children were attended by the doctor on the very first day of illness whereas, for the same illness, female children were attended only when the illness lasted for three

days or longer. But with respect to number of consultations made with the doctor, no sex discrimination was observed.

In both the landowning and landless groups, the average duration of treat ment given for boys lasted for one week. Whereas, the treatment for girls continued for more than two weeks. This may have been due to the slower attention to the girl children for initiation of treatment. As the illness of male children was attended as soon as symptoms develop, their treatment ended quickly. As girls were attended only when the illness was aggravated, naturally the duration of treatment lasted for a longer period.

3. Nutrition to the Girl Children

Even though landowners started giving solid food to their children earlier than landless labourers, no discrimination was observed on the basis of sex in both the groups. However, with regard to type of food given,in some families (both groups) male children were given more milk, fruits,etc.,than female children, which is due to parents' preference toward male children.

IV Data from Similar Studies

A study of two villages in West Bengal conducted by Chen et al (1981), rev ealed that girls consistently had poorer nutritional status than boys among all socioeconomic strata.

Research in Bangladesh conducted by UNFPA (1988) found that five year old boys were given 16 per cent more calories than girls and that girls were more likely to be malnourished in times of famine. In another study it was found that sick boys rather than girls were often taken to the city hospital, when they failed to recover from illness.

A study was conducted by Kapur.(1979) at a village near Delhi and reported that, even when conservative Hindu families can afford to feed an adequate meal to both male and female children, only the boys are given the rich diet and girls a much poorer one.

Another study was conducted by Gupta (1985), in Punjab State. He examined the impact of sex bias on children's nutritional status. It was observed that 95 per cent of the mothers were intent on ensuring the survival of atleast one male child. The average ratio of boys to girls that the parents perceived as ideal, was heavily in

favour of boys. Among the male children the percentage given adequate food and adequate care in feeding, was twice that of the female children.

V Conclusions

While sex discrimination in upper classes may take the form of differential access to resources and life opportunities, in poor families, it is extended even to basic necessities like food and health care. Thus, poverty has to be attacked on a war footing and at the same time it should not lose sight of special needs of girl children in poor families. With greater success of the Family Welfare Programme the number of children borne by poor parents would also decline. With a small family to take care of and with no fear of losing many of their children a child is not likely to be discriminated by sex in basic child care. Simultaneously, an intensive educational campaign has to be carried on, so that a new value system and a set of new attitudes can be imbibed in the minds of the people.

VI Summary

This paper is based on data obtained from a village near Coimbatore in Tamil Nadu and it examines the patterns of health care rendered to male and female children among peasant and landless households. Breast feeding has been measured in terms of frequency and duration. Other health care parameters are also studied such as the system of medicine utilized during illness, time lapse before care is initiated after the manifestation of diseases, number of consult ations, made and duration of treatment. Regularity of meals to children was also explored.

On the whole, women among landowning class continued their breast freeding for a longer period than the peasant women, the average duration being 21.57 months and 20.00 months respectively. But no discrimination was observed between male and female children either in duration or in frequency of breast feeding. No sex discrimination was observed with regard to treatment during illness of children of landowners. Among landless labourers, females were observed to be taken to native practitioner more commonly, whereas sons were being taken to the allopaths for their illness. It was also observed that males were given medical care in the early stage of disease itself, compared to female children who were provided treatment only when the illness was prolonged. With regard to number of consultations made for the illness, no differences were found between the sexes. Since the female

children were given treatment only when it became severe, the duration of treatment tended to last for a longer period than in the case of male children.

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7. SEX DIFFERENTIALS IN NUTRITIONAL STATUS AND CHILD MORTALITY:

SOME RESULTS FROM MICRO-LEVEL STUDIES

A.Basu, P.Bharati*, B. Mukhopadhyay* and R.Gupta**

I Introduction

It is a common notion that the girl child relative to the male child, generally suffers from neglect, and all its corollaries. The brochure on this Conference mentions a one-third to one-half greater risk of death, due to economic and social exploitation and the consequent additional health hazards, of the former. The girl children have accordingly been treated as one of the most vulnerable groups of the Indian population, which needs adequate attention of the scientists and administrators. The choice of this theme reflects the general concern for the girl child, especially in the South Asian region, as evidenced by the declaration of the 1990s as the 'Decade of the Girl Child' by SAARC.

The objective of this paper is to present some micro-level data on sex differentials in nutritional intake and child mortality, from populations inhabitating contrasting ecological zones studied by us in recent years. Some readily available macro-level data on mortality and morbidity are also presented to provide the perspective.

II Macro - Level Data on Sex Differentials in Infant Mortality

Some macro-level data, albeit somewhat dated, are presented in Tables 1,2 and 3. The tables show that generally, neonatal mortality is higher in males than in females in both rural and urban areas, contrary to the common notion of a higher female mortality due to neglect; the trend is less clear in case of post-neonatal mortality, some States showing higher values for females (Table 1). Infant mortality, which is the sum total of neonatal and post-neonatal mortality, also shows a similar, though less clear trend than the former. Table 2 shows similar trends in case of the two major religiousgroups, Hindus and Muslims. Table 3 shows a higher male infant mortality, consistently, over decades 1941-50, 1951-60 and

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1961-70. As to the major causes of death, Table 4 sho ws that female infants die more frequently of fever and perhaps diarrhoea, but not the other causes. The dates are undoubtedly dated, and the causes of death rather vague, but they suffice to indicate that the female infants are not necessarily more vulnerable to death. Thus, the macro-level data do not corroborate the common notion that the female child is relatively more vulnerable to health hazards and death.

III Micro- Level Data on Sex Differentials in Health Status

In the context of this general scenario, we shall look at some micro-level data collected by us over the last one-and-half decades.

III.1 Nutritional Status

It is generally believed that a bias exists in favour of the male (especially male child) vis-a-vis the female child in intra-household food distribution(den Hartog 1972). In an occassional paper of the World Bank (1983), it has been postulated that an important motivation for this bias is possibly that the males are the provider, actual or potential, of food to the household and therefore should be looked after well in the interest of the household. In India, the male bias has been suggested to have emerged in the context of the traditional ancient Hindu Society (India 1955). This has been reported on the basis of empirical data by Levinson (1974), Gulati (1978), Batliwala (1983)and Agarwal (1984). Sen and Sengupta(1983) studied the nutritional status of children under five years of age in two villages near Shantiniketan in West Bengal and found greater deprivation of girls vis-a-vis boys. They also found greater sex discrimination in the case of the village which had better overall nutritional stat us.

Over view of the data on the Sherpas and Lepchas (certain tribal groups) of Kalimpong subdivision, Darjeeling district, and the Mahishyas of Uluberia subdivision, Howrah district, are presented here. The Mahishyas were divided into High, Middle and Low economic groups, using the then 'poverty line' and the locally-defined 'sufficiency line' in the mid-1970s as the cut-off points between the Low and Middle, and Middle and High groups, respectively. The essential objective of the study was to examine

whether the general belief of a male bias in intra-household food distribution was valid for these populations and their subgroups.

Individual-wise dietary intake data were collected from each household using the one-day semi-quantitative recall method from the wife/mother, who actually distributed the food to household members. From the dietary intake, calorie intake was estimated using ICMR's (1981) conversion tables. The actual calorie intake thus estimated was compared with the age/sex-specific calorie intake for age recommended by ICMR (1981). Eight categories of household members were considered. The eight categories of household members were ranked on the basis of the numerical value of the difference between actual and recommended intakes as shown in. An analysis of variance was performed to test the significance level of the 'actual vs recommended' difference, considering all the eight categories in each population/ subpopulation.

The results of our study showed that only in the High-economic groups Mahishyas, a clear male bias exists; three of the upper four ranks being occupied by the males. The household head (male) occupies the highest rank and the male child the third, suggesting that the bias is more in favour of the adult than the child. In the Mahishya Middle and Low economic groups, there is no inequita bility among household members, i.e. each member receives calories proportional to his/her need. In all the other groups, the inequitability among household members is significant, but there is no consistent pattern. For instance, in the Lepchas, females occupy three of the upper four intake ranks irrespective of urban/rural and Buddhist/Christian differences. In the Sherpas there is no clear pattern, except that both husband and wife occupy positions among the four lower ranks. Overall, then, there is no evidence of any general neglect, and economic and social exploitation and consequent health hazards, of the female child in these three population samples from two contrasting ecological zon es.

III.2 Child Mortality

It is generally believed that death below 28 days of an infant's age reflects the effects of endogenous factors, and thereafter the effects of exogenous factors, particularly health facilities available to the group. (Mitra, 1978; Ashworth, 1982). In our surveys, we do not have data separately for neonatal mortality(i.e.death below 28

days). We have compared infant mortality (i.e. death below one year), of which neonatal mortality is a major component, with todd ler mortality (i.e. death between one and four years). The basic premise in this comparison is that post-neonatal mortality shows the effects of exogenous factors like health facilities, more than neonatal mortality, and that logically extending from this observation one may deduce that toddler mortality shows the effect of exogenous factors more than infant mortality.

III.3 Sex Differentials in Mortality

In the three populations mentioned above, information was collected from each ever-married woman on her reproductive performance,i.e. live births, dead children, age at the time of death of dead children and age presently of live children. The data were collected in the form of a pedigree in which each individual child was separately recorded. The information was cross-checked from several additional sources, e.g. the husband, any other adult or elderly woman of the household, close neighbours, etc. Ages were estimated with reference to important local events, ages of individuals for whom age records were available, and so on.

The data are presented in Table 5-8. Our data presented in Table 5 show that in the Mahishyas, males have a higher infant mortality than females in all the economic groups. Further, the infant mortality declines from the Low through Middle to High economic group in both males and females, but the decline is greater in case of males. Two points emerge from these findings : (1) males, rather than females, are at a disadvantage at less than one year of age; and (2) the latter finding (of a lesser decline of infant mortality with improvement of economic status in females compared to males), corroborates the general belief that females are less responsive to improved health facilities, presumably because of their in-built greater resistance to health hazards in the natural environment compared to males (Mitra, 1978). Incidentally, females are generally believed to be biologically more stable, i.e. more capable of withstanding environmental insults, than males. Higher infant mortality of males compared to females also occurs in case of the Lepchas whether we subdivide the sample by urban/rural habitat or Buddhist/Christian religion (Table 6). The same finding emerges from our data on the two Sherpa groups,one inhabiting the high altitudes of Nepal and the other the relatively lower altitudes in the Kalimpong subdivision, Darjeeling district,

West Bengal (Table 7). Overall, then, there is no evidence of any general neglect, and economic and social exploitation and consequent health hazards, of the female child in these three populations.

We now turn our attention to toddler mortaility which may be expected to show the effects of exogenous factors such as health facilities, more than infant mortality. Intuitively, males wih their in-built lesser resistance to health hazards in the natural environment may be expected to benefit more from the improvement of health faciliies, compared to females. Going back to Table 5, it appears that toddler mortality is lower than infant mortality in all three economic groups and both sexes. Indeed, males have benefitted more than females from the exogenous factors (ike health facilities), as suggested by a lower toddler mortality of males in both Low and Middle economic groups. Further, toddler mortality of males is much lower than females in the Middle, rather than in the Low economic group, suggesting that males have benefitted more from the improvement of economic status from the Low to the Middle economic group. (The High economic group stand out as an exception, for which no explanation is offered). We had an opportunity of undertaking a re-survey of the same village population in 1988, exactly 10 years after the initial survey in 1978. The results (Table 8) show very much the same pattern as in Table 4 discussed above, in addition to showing general decline of both infant and toddler mortalities over the ten year period, presumably as a result of the general improvement of health facilities over this period.

Now, going back to the basic objective of this presentation, the toddler mortality figures do show that the females are indeed at a disadvantage at this phase of life in this population both in 1978 and 1988, except in the High economic group. Is the situation similar in the Lepchas and Sherpas? Tables 6 and 7 show that unlike in case of the Mahishyas, the pattern of toddler mortality in both Lepchas and Sherpas is similar to that of infant mortality,i.e. males have higher values than females, and this is true whether we subdivide the Lepcha sample by urban/rural habitat or Buddhist/Christian religion, or subdivide the Sherpa sample by low/high altitude of residence.

III Summary

In summary, then, let us conclude with a discordant, but not unpleasant note. Our micro-level data on three population samples from two contrasting physical environmental zones and two broad social categories (Hindus and tribals), showed no evidence of any neglect, economic and/or social exploitation and the consequent additional health hazards of the girl child, judging by calorie intakes and child mortalities, in general.

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Table -1a
Neonatal, Postneonatal, and Infant Mortalities by Sex and States
(NSS, 18th Round, July 1964 - June 1965m Rural)

State	Neonatal		Postneonatal		Infant	
	Male	Female	Male	Female	Male	Female
Andhra Pradesh	71.20	59.28	50.56	34.02	121.76	93.28
Assam	43.96	46.56	37.36	35.48	81.32	82.04
Bihar	82.09	63.88	42.54	49.43	124.63	113.31
Gujarat	56.25	34.01	40.62	34.01	96.87	68.02
Haryana	230.26	212.93	19.74	22.81	250.00	235.74
Jammu & Kashmir	38.80	19.71	29.98	44.80	68.75	64.51
Kerala	34.40	31.54	29.16	14.84	63.46	46.38
Madhya Pradesh	57.80	48.39	57.10	71.85	114.90	120.24
Madras	67.38	54.45	25.73	23.90	93.11	78.35
Maharashtra	38.17	32.07	42.75	41.35	80.92	73.42
Mysore	109.01	100.00	21.80	4.35	130.81	104.35
Orissa	57.65	47.72	35.79	39.42	93.44	87.14
Punjab	62.19	49.05	39.80	19.07	101.99	68.12
Rajasthan	57.78	51.05	50.00	85.08	107.78	136.13
Uttar Pradesh	77.97	65.60	82.82	94.55	160.79	163.15
West Bengal	49.69	44.90	34.78	32.77	84.47	77.67
All-India	68.98	57.64	49.63	52.49	118.61	110.13

Source: Mitra, 1978

Table-1b:
Neonatal, Postneonatal and Infant Mortality Rates by Sex and States - Rate per 1000 live births
(NSS, 19th Round, July 1964 - June 1965, Urban)

State	Neonatal		Postneonatal		Infant	
	Male	Female	Male	Female	Male	Female
Andhra Pradesh	48.10	32.17	18.99	33.51	67.09	65.68
Assam	53.80	14.81	44.30	12.35	98.10	27.16
Bihar	58.92	47.54	47.46	28.17	106.38	75.71
Gujarat	29.97	10.34	41.46	31.01	70.73	41.35
Haryana	80.29	29.13	43.80	-	124.09	-
Jammu & Kashmir	11.49	24.69	30.65	12.35	42.14	37.04
Kerala	25.79	12.35	5.73	49.38	31.52	61.73
Madhya Pradesh	49.70	29.06	34.32	31.48	84.02	60.54
Madras	54.74	36.72	30.71	32.49	85.45	69.21
Maharashtra	43.24	32.88	25.89	23.64	69.13	56.52
Mysore	67.37	38.55	40.00	27.21	107.37	65.76
Orissa	26.57	40.58	24.15	37.68	50.72	78.26
Punjab	64.29	11.19	46.43	41.04	110.72	52.23
Rajasthan	72.60	43.48	36.30	69.94	108.90	113.42
Uttar Pradesh	81.26	60.11	53.55	61.07	134.81	121.18
West Bengal	34.60	30.58	39.79	25.18	74.39	55.76
All-India	53.08	35.40	35.65	35.07	88.73	70.47

Source: Mitra, 1978.

Tab1e - 2 :
Neonatal, Postneonatal and Infant Mortalities by sex for
Hindus and Muslims (NSS, 19th Round, July 1964 - June 1965)

Religion	Neonatal		Postneonatal		Infant	
	Male	Female	Male	Female	Male	Female
Rural						
Hindus						
Rate	68.90	57.84	49.00	53.40	117.93	111.24
Sample	846	645	568	568	1414	1219
Muslims						
Rate	72.87	51.69	59.33	54.38	132.20	106.07
Sample	98	65	80	76	178	141
Urban						
Hindus						
Rate	50.15	33.98	38.16	34.91	88.31	68.89
Sample	286	175	195	173	481	348
Muslims						
Rate	68.87	46.75	29.66	40.49	98.53	87.24
Sample	74	51	37	47	111	98

Source : Mitra, 1978.

Table - 3:
Infant mortality by Decade

Decade	Male	Female
1941 - 50	190.0	175.0
1951 - 60	153.2	138.0
1961 - 70	135.0	130.3

Table - 4:

Percent of Infant deaths by cause of death and sex, 1966 - 68.

	Percent of Infant Deaths					
	1966		1967		1968	
	Male	Female	Male	Female	Male	Female
Violence or Injury	0.7	0.4	0.6	0.3	0.3	0.4
Childbirth/Complicated Pregnancy	-		-	-	-	-
Diarrhoea	9.9	13.5	9.3	9.1	8.7	9.9
Swelling	1.2	0.6	1.1	1.2	0.8	0.8
Fever	13.5	15.8	14.2	16.3	11.6	12.5
Cough	25.5	23.6	22.0	20.5	19.6	20.4
Other Infant Deaths	40.9	40.0	46.3	45.8	50.0	48.4
Other Clear Symptoms	6.1	1.3	5.8	5.4	8.0	6.5
Other Vague Symptoms	2.2	1.8	1.7	1.4	1.0	1.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source : Mitra, 1978.

Table-5 :

Infant and Toddler Mortalities (%)by Sex and Economic Group: Chakpota (1978)

	Low		Middle		High	
Mortality	Male	Female	Male	Female	Male	Female
Infant	17.59	12.20	11.81	8.97	8.40	8.46
Toddler	3.70	4.88	1.39	3.17	2.94	2.49
Total number of live births	216	246	432	379	238	201
	462		811		439	

Table-6 :

Infant and Toddler Mortality by Sex, Habitat and Religion: Lepcha.

(%)

	Urban		Rural		Buddhist		Christian	
Mortality	Male	Female	Male	Female	Male	Female	Male	Female
Infant	7.63	5.04	8.99	7.11	11.68	7.78	6.06	5.18
Toddler	5.76	5.04	4.36	3.70	5.91	5.05	4.04	3.41
Total number of live births	590	556	1079	1027	728	733	941	950
	1146		2106		1461		1791	
	3252				3252			

Table-7 :

Infant and Toddler Mortalities by Sex and Habitat (altitude of residence) : Sherpa

(%)

	KPG (Low altitude)		Nepal (High altitude)	
Mortality	Male	Female	Male	Female
Infant	7.69	5.34	7.88	6.55
Toddler	5.29	4.63	5.45	2.99
Total number of Livebirths	624	562	165	168
	1186		333	

Table-8 :

Infant and Toddler Mortalities by Sex and Economic Group (%): Chakpota (1988)

Mortality	Low		Middle		High	
	Male	Female	Male	Female	Male	Female
Infant Mortality	13.90	11.70	11.11	8.78	5.06	8.42
Toddler Mortality	3.14	4.53	1.81	2.68	2.95	1.98
Total number of Livebirths	223	265	441	410	237	202
	488		851		439	

8. THE FEMALE CHILD IN INDIA

*B. Vishnu Bhat**

I Introduction

All over the world the sex ratio tends to favour the women since they are biologically the stronger sex. But in India, the ratio of females to males in the population has become alarmingly low. Even though Indian industry has been commended for its spectacular growth for impressive achievements in terms of the space research programme, growing foreign trade, and increasing computerization in many walks of life, the improvement in the status of women is far from satisfactory. Every year 12 million girls are born in India. Of them, 1.5 million die before their first birthdyay, another 850,000 before their fifth birthday and only 9 million will be alive at the age of 15 years.

II Present Status of the Female Child in India

Let us have a closer look at the plight of female children of our country.

II.1. Female Population

As per the 1981 census, the number of female children are less than males.

II.2 Age at Marriage

The mean age at marriage for females is 18.3 years and for males, 23.3 ye-ars. The mean age at marriage has increased gradually as shown below:

As per the 1971 census 22% of women were married at 13 years and 74% by 17 years of age, although the safe age for child bearing is 20-30 years. Many girls are mothers even before they have crossed their adolescence. In one of the community studies the reasons given for the early marriage (3) were:-

i) Society will condemn the parents if the daughters are not married early. The fathers will be looked down upon as if they live on their daughters earnings.

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ii) Among the poor peasants, sexual exploitation by the rich landlords is feared.

iii) Early marriage will reduce the financial burden on the parents since the cost of living is ever rising.

But early marriage brings the girl, motherhood and other added responsibilities at an early age.

II.3 Nutrition

It has been observed in some studies that the female babies are breast fed for shorter periods. Nutritious foods like milk, eggs, etc. are usually given to the male children. T he spirit of sacrifice is taught to the girl since childhood. She is often trained to be undemanding and to live on left overs. People often do not realize that only a healthy woman can give birth to a healthy baby. The birth weight of the baby is positively influenced by the height and weight of the mother or in other words her past nutritional status(4). The Anganwadi workers under the ICDS programme are expected to look after the preschool children and women in the child bearing age. Thus the female child in the pre and early adolescent period (6-15 years) is not adequately taken care of. But this period is very critical during which they should be given adequate support.

Studies from various parts of the country have shown that the female children consume lesser calories and proteins when compared to males (2). Studies from Bengal and Punjab have shown that there is high prevalence of protein - energy malnutrition among female children(5). But studies from Hyderabad(6) and Pondicherry (7) did not indicate such differences suggesting that the situation varies from place to place.

II.4 Education

Education helps the individual to think, act and accomplish goals. It helps the individual to adjust to the new situation and get employed productively. Education helps the social mobility of women and improves their self respect. But parents are inclined to spend less on the educatiion of their female children.

As per the 1981 census, the female literacy rate is almost half that of males with high school dropout rates.

Although the literacy rate for women has increased from 7.93% in 1951 to 24.82% in 1981, the figures are far from achieving universal education in the near future. The female children are enrolled in fewer numbers in the schools with high dropout rates. The percentage of women students studying in graduate and postgraduate courses are shown ib the table. Unless the women are educated, obviously they cannot be employed and in turn the social structure will remain unchanged.

II.5 Medical Facilities

The male children get a better deal in the health sector as well. It is quite common to find more male children in any health care delivery area. The outpatient and inpatient statistics from the hospitals show that the male to female ratio is almost 1.5:1(9,10). Infant mortality rate for male children is 95 and that for females 96. The life expectancy at birth for females is 52.1 and that for males 52.5(1). The age specific death rates also show that boys tend to get a better deal in life.

When the female child is sick or indisposed, she is not taken to a qualified doctor but given home remedies in order to reduce the cost. Immunization coverage studies in some areas of Uttar Pradesh have shown that significantly lesser number of female children are protected against the vaccine preventable diseases(11). This shows a definite point of discrimination.

II.6 Child Labour

Childhood is not enjoyed by most children in India, and girls are more affected. In Sivakasi, almost 45,000 girls are employed in match industries and 90% of them are less than 14 years (12). They are also employed in coir and papad industiries in Kerala, beedi and gem polishing industries in Rajasthan, brass industry in Uttar Pradesh, etc. It is observed that girls are paid less for similar jobs and employed more often in unskilled jobs. Similarly, the work done by women at the house is unrecognised since it is considered non-productive.

II.7 Female Infanticide and Foeticide

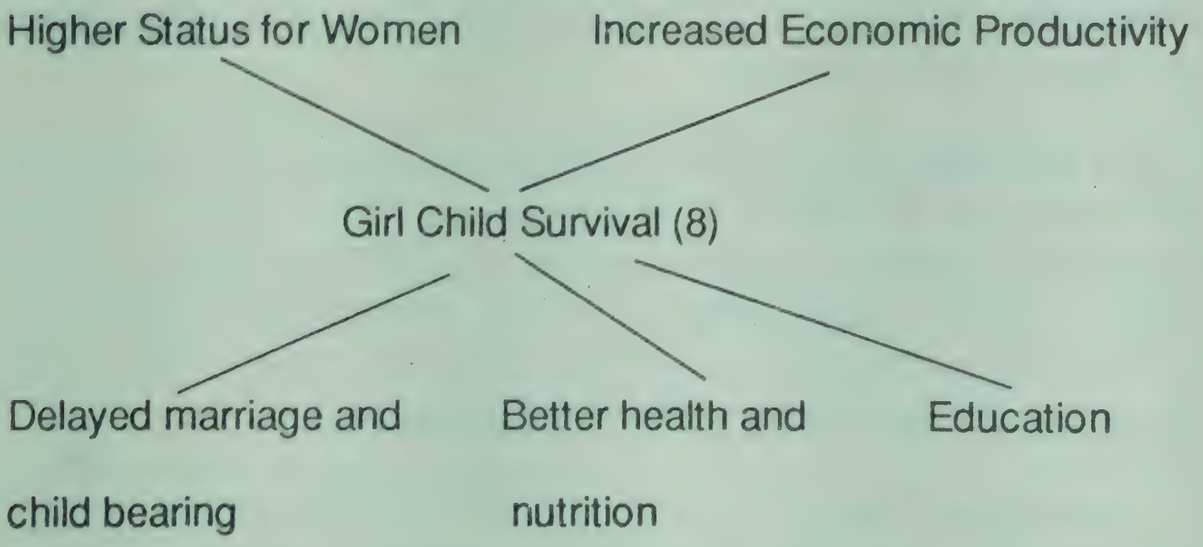
As a result of female infanticide among the Bhati community of Rajasthan, the sex ratio among them has become one of the lowest

in the world at 550. There has been no marriage procession (Barat) in some of these villages for years(13).

Usilampatti is a village in Madurai district of Tamil Nadu where female infanticide is rampant. The common methods used for killing are either to feed the female child with the poisonous milk from the erukku plant or putting a few grains of paddy in the infants mouth. The paddy grain usually chokes the child to death. In some cases it may cause bleeding from injury (14). Similarly, thirty-five female children from a single family were killed in Bharatpur, Rajasthan (15). For every case that is reported in the media, hundreds remain undiscovered. Although there is no exact figure for the number of female infants killed, it is quite large.

Modern science has also made its own contribution to the suppression of females in this country even before they are born. Amniocentesis was initiated for identifying the genetic abnormalities in the fetus. But, to-day it is being used to identify the gender of the unborn child. If it happens to be a female, termination of pregnancy is undertaken. During 1984, in Bombay alone 40,000 female foetuses were estimated to have been aborted. In 1987, Maharashtra State has banned sex abortions (15). But the practice is on in many cities of India even to-day.

III Strategies for Upliftment



The rights of the girl child are protected today on paper through the Constitution of India. We have been independent for more than four decades and have enacted a "National Policy for Children" and initiated a "National Commission for the development of Women". But we have achieved very little in uplifting the status of the female

chi ld. What we need to-day is a holistic approach and a bold thrust in improving the girl child's health, education and status.

There should be universal primary education. Women should realise themsel ves as constructive, independent individuals and not just helpless dependants on their parents and husbands. The education should involve not only the girl child but also the adult woman. There should be stress on the rural folk. Help from voluntary agencies, educational institutions and women's organisations should be sought. These actions should be well co-ordinated to be effective.

The health status of the female child should be improved. Sex discrimination wth regard to nutritional support should be removed. The Anganwadi workers,multipurpose health workers and school teachers can assist in this task. The ICDS programme is very essential in providing immunization coverage, nutritional supplementation and preschool education to the children. Every village and corner of the country should be covered under this programme. At present the ICDS project covers the preschool children and women in the child bearing age. But it is essential that female children in the vulnerable age group of 6-15 years are taken care of. This pre and early adolescent period coverage is important in order to bring about a desired change. During this period major social, biological and psychological changes take place. The adolescent growth spurt will get blunted if proper nutrition is not provided during this period.

It is essential that economic status of the population is improved and poverty is eliminated. Poverty is one of the most important constraints against any development. Formal education will help them in getting useful and productive employment. Once the women are employed and earning, they will have a say in the day-to-day family affairs and decision making.

There should be a ban on child labour. This should be not just on paper but in reality. The children should spend their time in education and playing and not in earning a meagre livelihood. This can be achieved through reducing the family size and general economic upliftment of the masses.

The minimum age at marriage has to be raised to 20 years. But this will involve change in the attitude of people. Once there is a

socioeconomic uplifting, the attitude of people will change. This will require nonformal education through radio and television regularly.

In the early Vedic era, there existed equality between males and females. As Manu, the ancient law giver put it, "where the females are in grief, the family perishes and where they are happy, the family flourishes". With advance in every sphere of life we should see that the rights of the female child are not neglected but well protected. Then only we can achieve 'Health for All includi ng the female child by 2000 AD'.

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Table 1
Population of Children in million (0-19 years)

	Males	Females
Rural	131.1	121.8
Urban	38.7	35.7
Total	169.8	157.5

Table 2
Sex ratio (females per 1000 males)

Age group	No.of females/1000 males
All ages	933
0 - 4 years	957
5 - 9 years	942
10-14 years	911
15-19 years	885
0 -19 years	927

Table 3
Mean age at marriage for Girls

Years of data	Mean age at marriage
1911	13.2 years
1951	15.6 years
1971	17.2 years
1981	18.3 years

Table 4
Literacy rate (percent)

Age Group	Males	Females
All ages	46.89	24.82
5 - 19 years	54.46	36.91

Table 5
School enrolment ratio 1988-89 (percent)

Group	Boys	Girls
I - V Class	115.7	82.5
Vi - VII Class	70.8	42.3

Table 6
School dropout rates (1985-86) (percent)

Group	Boys	Girls
I - V Class	45.84	50.27
VI - VIII Class	60.70	70.84

Table 7
Percentage of children attending schools in a few States (5-9 years of age)

State/India	Boys	Girls
India	44.3	32.2
Kerala	75.1	75.1 (Highest)
Tamil Nadu	63.9	54.6
Uttar Pradesh	32.1	17.4 (Lowest)

Table 8
Percentage of Women Students Studying (1987-88)

Courses	% of Female Students
Graduate Courses	31.3
Postgraduate Courses	32.7
Arts	42.7
Science	32.2
Education	51.8
Engineering/Technical	6.2
Medicine	31.1

Table 9
Percentage death rates

Age group (in years)	Males	Females
0 - 4	33.6	36.8
5 - 9	2.8	3.9
10 - 14	1.5	1.4
15 - 19	1.9	2.5

9. FACTORS RESPONSIBLE FOR SCHOOL DROPOUT AMONG GIRLS

Sr. Pushpa Francis, Helen Thasian*, Rajaratnam Abel**

I Introduction

School dropout is as much a process as it is an event. The term dropout in educational system includes all cases who sever their contact with the educational system before reaching the expected end of the continuum.

School education is the cornerstone of social and economic betterment in contemporary society. It is also one of the most powerful instruments of social change and development. After Independence, the Central and State Governments have made liberal Plan allocations to improve the educational system of the girls. Besides, a variety of facilities were extended to promote rapid diffusion of education in the community. Inspite of this, there is a glaring disparity of educational status between urban and rural girls. Unless we have adequate and authentic data on the factors responsible, no worthwhile policies and programmes can be developed to deal with this problem.

II Data from Other Studies

The problem of school dropout among girls can be studied through different angles. Bhaskaran (1) pointed out the obstacles in achieving equal education for women, such as social, economic, cultural and political reasons which are interwoven and which create attitudes unfavourable for the learning process of girls and women. Alexandra Joshua (2) brought out the reasons given by the respondents as, poverty, academic failure, stagnation, excessive involvement in household duties, and the general attitude that educating girls was not proper. T.N.Shukla (3) presented other views on the reasons for school dropout, which according to him, included lack of adjustment, lack of facilities, irregularity in attendance because of various circumstances, under-nourishment, frequent illness, economic backwardness, frustration with the educational system, shyness about age, etc. Roopa Vohra(4) also listed out the various reasons which compelled girls to discontinue their schooling. Girls are expected to assume responsibility for

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housework at an early age, such as helping her mother in the household work, looking after the younger children, etc.

II Objectives of the Study

This study has the following aims and objectives:

1) To estimate the proportion of school dropout from Std.VIth to Std.Xth in a rural school among girls.

2) To identify the factors responsible.

3) To analyse the socioeconomic status of the school dropout.

4) To list out the suggestions given by the dropouts, their parents and school teachers for reducing school dropout among girls.

III Materials and Methods

The study was carried out in the Girls Higher Secondary School, Veppaneri Panchayat of K.V.Kuppam Block, the programme area of RUHSA, situated in a rural background. The total population of K.V.Kuppam Block is 1,03,090 according to a recent survey conducted in 1986 by RUHSA. Veppaneri a rural panchayat of K.V.Kuppam Block is situated on the main road that connects Gudiyatham and Katpadi. Children residing within the radius of 5-8 km. study in this school.

The study focussed on the factors responsible for school dropout among girls. Operationally, dropouts are defined as those girls who, after enrolment, leave the school permanently before completing the process of education. Out of 105 such dropouts identified through contacts with the Headmistress of the school and from school registers, 46 were selected by using systematic random sampling.

Keeping in view the basic assumption that parents and other family members do influence dropout, care was taken to see in each case, that both the parents and all the children including the dropout were present during the interview. The interview was conducted mostly during evenings and sometimes during day time. The initial contact was made through the Headmistress of the school. The study was conducted between 10th August 1990 to 10th December 1990. Difficulties in the pilot stages were identified

by the independent observation. The methods were refined and then the final study was carried out.

IV Results

IV.1 Reasons for Dropout

The Table 1(a) reveals that 41.3% of the parents stated the reason of academic failure, 19.6% of them stated that their daughters' marriage was the reason for dropout. It is indeed notable that 17.4% of the parents were not able to afford schooling, while the others have stated economic problem, transport problem, illness and attaining puberty as the reason for dropout.

Table 1(b) shows the opinion of teachers about the cause of dropout among girls in their school.

The table is self explanatory as it shows poverty as the main reason for dropout. The table shows 80% of the girls stopped their schooling due to poverty.

IV.2 Social Background of Dropouts

About 63.0% of the dropouts belonged to BC, whereas 28% were SCs and 8.7% belonged to other forward caste groups . From the above table, it is clear that 39% of the dropouts were from the age group of 18-19 years, whereas 32.6% and 21.7% were from 16-17 and 14-15 years respectively.

V Discussion

The study has brought out the fact that dropout from school is more among the girls of 18-19 years age group in this particular rural panchayat. Though the reasons are many, academic failure and early marriage seemed to be the major reasons. A very small percentage have indicated isolation of their village from the main road as one of the reasons.

It is a noteworthy point for discussion that almost 64% of girls have said that they themselves were responsible for discontinuing their schooling. Some sort of reformatory action, therefore is called for from the state as well as the society. Here are some of the suggestions for action:

1) Some motivation campaign should be held for parents and girls on female education and disadvantages of early marriage.

2) The academically weaker female students should be provided additional coaching class facility.

3) Parents belonging to lower economic status should be identified and helped through the available government loan facilities, and also should be motivated for self employment.

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Table 1(a)
Distribution of reasons for school dropout stated by the parents

Sl.No	Reasons	No.	%
1.	Too many Children/can't afford	8	17.4
2.	Academic failure	19	41.3
3.	Marriage	9	19.6
4.	Economic Problem	4	8.7
5.	Transport difficulty	2	4.3
6.	Illness	2	4.3
7.	Shyness after maturity	2	4.3
	Total	46	99.9

Table 1(b)
Class Teachers Statements on Reason for Dropout

Sl.No.	Reasons	No.	%
1.	Poverty	4	80
2.	Puberty	2	40
3.	Carelessness of the parents	1	20
4.	Failure	1	20
5.	Low value for education	1	20
6.	Distance	1	20
7.	Illiteracy	1	20
8.	Lack of interest by the parents	1	20

Table No.2(a)
Caste Distribution of Dropouts

S.No.	Caste	No.	%
1.	Scheduled Caste (SC)	13	28.3
2.	Backward Community	29	63.0
3.	Others	4	8.7
	Total	46	100.0

Table No.2(b):
Distribution of the age of the Drop Outs

S.No.	Age	No.	%
1.	12-13 years	1	2.2
2.	14-15 years	10	21.7
3.	16-17 years	15	32.6
4.	18-19 years	18	39.1
5.	20 +	2	4.4
	Total	46	100.0

10. ASSESSMENT OF MEDICOSOCIAL PROBLEMS AND PERSONALITY PROFILE OF WOMEN IN DESTITUTE HOME,NAGPUR.

*Akarte S.V *, Ketkar Y.A**, Purankar D.Y***.*

I Introduction

Medicine, in its broadening scope, is looked upon as a sum total of activities of society that tend to promote and restore health and prevent illness. Where this concept prevails, medicine becomes a social science with social goals, and consequently attention is focussed on the external environment, i.e. physical and social environment, rather than internal body environment. Social growth of the individual starts within the family. Adverse conditions prevailing in the environment act on man causing derangement in physical, mental and social health which may manifest in the form of disease, mental illness or social problem. The adult's response to situations is not an intrinsic racial characteristic, but is influenced by the manner in which he is reared and educated in the family. The study of social problems is becoming important recently, since social factors are implicated in development of communicable and non communicable diseases, nutritional disorders and mental health status. Social factors also influence the organisation of health services and future planning.

II Objectives of the Study

1) To study various medicosocial problems of women in destitute homes.

2) To obtain the personality profiles of these women as a group and compare with control population (Anchor reference group).

3) To assess the rehabilitation measures available.

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** *Professor & Head, Preventive & Social Medicine, Krishna Institute of Medical Sciences, Karad.*

*** *Professor & Head, Psychology, SNDT College, Pune.*

III Materials and Methods

The study was carried out in a destitute home for women at Nagpur. Women of 18 years and above are admitted here for various social problems. During the period of study, a total of 50 inmates were resident and all were studied. Subjects were interviewed confidentially with predesigned and pretested questionnaires and also physically examined. Personality profile was assessed as a group with the help of 16 personality factors test and compared with normal population group (Anchor Reference group). The available rehabilitation measures were reviewed and possibility of additional measures was ascertained. On analysis,following results were obtained.

IV Results and Discussion

Out of 50 inmates, 42 (84%) were in the age group of 18-25 years, 7(14%) were between 26-30 years, only one was 38 years old. Thus showing higher percentage of women in younger age group. Forty were Hindu, four were Muslim and six were Christian. Five were illiterate and 21 had primary education and 24 had secondary education. Majority had education in the same institution. 35 were unmarried and 15 were married and deserted. Age at marriage was less than 15 years in five and less than 20 years in ten.

Prior to the admission in this insititute, 24 had resided in certified schools and other destitute homes, nine had been staying with parents, seven with relatives and ten had been living with husband.

Conditions in the family and individual which necessiated admission were, broken homes, (36% belonged to broken homes) addictions, (74% gave H/O addictions in family), criminality, maladjustment, illtreatment, quarrels, physical handicaps. All deserted wives were in the age group of 20-25 years. Early age at marriage and desertion are significant facotors, since this may put them under emotional stress and lead to suicides and psychological problems. Eleven married women had joint families. Reasons given for desertion were, being the second wife, wife-beating, marriage against will, criminality of husband. Place of origin could not be ascertained from all subjects, urban- rural distribution of problems could not be studied. The occupation of their families was labour work, tailoring, helpers, farming etc., with income ranging from Rs.100-600 per month. Both parents were

alive only in case of ten subjects. Duration of stay in the insititution varied from 0 months to 10 years. Out of 15 deserted wives, eight wanted to go back to husband and seven wanted to remarry someone else. 24 unmarried women wanted to marry. The remaining did not respond to the question.

Previous studies have also shown such problems. Criminal behaviour is associated with parent- child relationship and physical abnormality. Social inheritance, particularly emotional and cultural pattern in the family in which the child is born, is of paramount importance. Thirteen subjects had habit of chewing tobacco and pan. Table No.2 shows H/O of past illnesses in women.

General and systemic examination of subjects did not reveal any significant health problem. Physical abnormalities seen in women are shown in Table No.3.

Besides those shown in the Table, two had corneal opacities in one eye and one had enopthalmos. Amongst 15 married, five were mothers and only two had the child with them. 42 appeared to be depressed and eight were in an irritable state of mind. This finding is empirical as it is based on general impression at the time of interview. Ten women were found to be lesbians, out of which nine are unmarried and one is married. More details about sexual problems cou ld not be studied due to reluctance of the women to share this information.

The results of study of 16 personality factors test are as shown in Table.4.

Mean scores of cases under consideration were calculated. For relative assessment of this group, the mean scores of anchor reference group are also given and comparison was made. Significant difference in personality profile was found statistically, as shown above. The table shows that this group diff ers from normal population group in 12 out of 16 dimensions significantly. It is known that social problems do have adverse effect on personality. It is difficult to conclude from this study whether the differences in personality profile are due to the effect of institutionalization or effect of circumstances prior to admission or childhood.

Rehabilitation measures available are at the institution were primary education, tailoring diploma, training in household work.

Production units are organized such as stitching clothes and grinding of spices. Insititution also plans for marriages and efforts are made to send these women back to their homes. The recreation available consists of reading books and gardening. At times they are taken out for visits, picnics and movies. At the time of study, six were working for tailoring diploma, two were studying and five were working outside (three as anganwadi workers, two as attendants in private nursing homes).

V Recommendations

More rehabilitation measures are necessary such as secondary and college education, typing and stenography, spinning, weaving and other productive jobs, so that they would become self sufficient. Medical education should be reoriented to identify these problems. The services of a part time lady medical officer, social worker and visiting psychologist should be made available, for periodic assessment of physical health, mental health, and social problems.

VI Conclusions

The study showed that psychosocial variables need more attention than physical variables of health. Physical abnormality is a additional problem which aggravates the social problem. Institutionalized subjects reveal only a fraction of social problems in community. India's gradual shift from simple agricultural economy to a complex industrialized one, rural to urban shift,breakdown of joint family systems, associated with poverty and illiteracy will inevitably accentuate these problems which ultimately will need more social services with more emphasis on rehabilitation of such individuals, so as to enable these individuals to return to society for normal life.

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Table 1
Reasons for Admission

Reasons	No. of Women
Destitution	17
Desertion	14
Victims of immoral traffic	4
Unmarried motherhood	1
Attempted suicide	1
Domestic diffculties	13
Total	50

Table 2
Past H/O illness

Illness	No. of Women
Typhoid fever	5
Tuberculosis	1
Rheumatism	1
Meningitis	1
Small Pox	1
Poliomyelitis	1
Chr. Otitis media	2
Epilepsy	1
Bronchial Asthma	2
Injuries	4
Operation	3
Total	21

Table 3
Physical Abnormalities in the Women

Abnormality	No. of Women
Congenital genu valgum	1
Post polio paralysis of left leg	1
Fracture left hip joint with Residual abnormality	1
Absence of fingers & toes	1
Cleft palate	1
Deaf & Dumb	1
Wrist drop and foot drop	1
Total	7

Table 4
Sixteen Personality Factors Test

Dimensions	Institution-allied Group		Anchor Ref.Group	Probability
	Mean Score	S.E. (Plus or minus)	Mean Score	
A. Aloof-vs-Warm	5.82	0.33	7.79	<.01
B. Dull-vs-Bright	2.59	0.18	3.69	< .01
C. Emotional/vs/Mature	5.80	0.29	7.52	< .01
E. Submissive-vs- Dominant	4.55	0.32	6.33	< .01
F. Glum-vs-Enthusiastic	5.96	0.30	6.16	< .05
G. Casual-vs-Conscientious	8.53	0.28	7.8	< .05
H. Timid-vs-Adventurous	6.06	0.38	7.21	< .01
I. Tough-vs-Sensitive	5.92	0.30	5.81	< .05
L. Trustful-vs-Suspicious	5.94	0.30	5.41	< .05
M. Conventional-vs- Eccentric	7.28	0.28	5.79	< .01
N. Simple-vs-Sophisticated	7.63	0.30	5.16	< .01
O. Confident-vs-Insecure	9.02	0.28	5.93	< .01
Q1. Conservative-Vs-Experimenting	7.88	0.32	7.00	< 0.5
Q2. Dependent-vs-Selfsufficient	6.08	0.36	5.35	< .05
Q3. Uncontrolled-vs- Self controlled	5.61	0.35	7.00	< .01
Q4. Stable-vs-Tense	6.98	0.36	5.78	< .01

11.GIRL CHILD, YOU ARE EQUAL TO YOUR BROTHER

*Sr. Agnesita**

I Introduction

When I think of a girl child, two incidents flash across my mind. A woman in Bihar had had eight abortions one after another. In desperation, her family brought her to the hospital. We, doctors, advised her complete bed rest. The family was willing to admit the woman in one of the private rooms of the hospital. She was there for more than three months. What a joy it was for the doctors, when she delivered a full term baby without any complications. I went to visit the woman, to congratulate her and to share her joy. As I entered the room, I was taken aback by the gloomy atmosphere there. Instead of beaming, radiant and smiling faces, sullen, sour and sad faces gazed at me. No explanation was forthcoming. The baby was well, lively, kicking and yelling. But the woman had tears in her eyes. After a few moments, someone whispered: "unfortunately a baby girl is born". So, that is it. Later on when I was alone with the woman, she asked me; 'Don't you know doctor, that a woman is divorced if her first born happens to be a girl?' No, I did not know. I was learning the hard realities of the life of woman, of a Girl Child.

I spoke to the women in the obstetric wards. They confirmed the fact that the usual practice in some parts of Bihar was to divorce a woman, if her first child happened to be a girl. Women in the wards were tense and anxious, not because of the anticipated labour pains, but because of the consequences that awaited them if they gave birth to a girl child. Some husbands might not divorce their wives, but then women have to settle down for life long harrasment and persecution. I spoke to the husbands and relatives of these women. But it was of not use. That was way back in 1976.

The second incident was as late as 1990. A woman delivered a cute little baby girl at our health centre. On being told that the child was a girl, the mother did not turn her head to look at her baby. The grandmother turned to the wall, became stonestiff and refused to touch the baby. " What are we to do with her?" they asked.

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II Gender Bias - Institutionalised Violence Against the Girl Child

All of us are familiar with similar scenes that take place in our hospitals, clinics and health centres. "Son preference", and sex bias are the unwritten laws of our society which are unconsciously imbibed and unquestioningly practised. The structured, systematic and institutionalised (family, society, law etc.) violence against the girl child is considered the accepted norm to be practiced. Such practices become the unchanging part of the life style in our society that even women feel guilty if they do not practice such a code of con duct.

II.1. Sex Determination Tests

Medical intelligensia discovered amniocentesis and sex determination tests to detect genetic disorders while human life was still in its foetal stage. The greedy, unscrupulous doctors, technicians, nursing homes and hospitals jumped at the opportunity that S.D. tests be offered. They set ablaze the smouldering suppression that the women suffered. S.D. Clinics sprang up in various cities and towns of the country. Advertisements appeared in suburban trains, on street walls and in magazines. Were all these S.D.Tests done to determine genetic disorders? We know the truth. Out of 8,000 abortions conducted after S.D. tests in Bombay, 7,900 were female babies. S.D. tests and subsequent selective abortion was also advertised by doctors as one of the effective method of family planning.

II.2 Female Foeticide

The United Nations Convention was held on the Rights of the Child at its General Assembly on November 20, 1990, and it has come into force as an international law. It was ratified by more than 30 National Governments. India supported its adoption. However, when we talk about the rights of the child and health of the child, have we thought about their right to be born? Has the girl child a right to be born? This is a big question mark.

Persistent and persevering protests from social activists and women's organisations forced Maharashtra Government to ban S.D. tests. That was an achievement in the right direction. Does it mean that S.D. tests are not done and female foeticide is not carried

out? A flourishing business which brings enormous economic gain does not automatically stop because government passes a law banning it. Banning these crimes may send them underground, may make them more costly and clandestine. Certainly S.D. tests are done, but at higher prices, because it has to be done without the culprits being nabbed.(atleast in Maharashtra). It is also certain that S.D tests and female foeticide are quite widespread in other cities and towns of India. Otherwise government would not have been talking about the need for passing a national law banning S.D. tests (Ind. Exp. March 7, 1991).

As more and more sophisticated and safer S.D. tests like chorionic villi biopsy and fluorescent tests become prevalent and available to people, will there be any restricting hand that will curtail this wilful weeding of weaker sex (weaker because they are defenseless)? Or will the medical science allow itself to be exploited and become a partner in the social conspiracy of promoting gender bias? It is for medical profession to defend and protect human lives. A ban on S.D. tests will express our concern for the girl child and for her right to life.

II.3 Female Infanticide

People in rural areas are not so lucky as their counterparts in urban areas. Medical facilities for S.D. tests are not available in villages and small towns. So there is no opportunity for selective abortion. But "son preference" and sex bias in rural areas is as strong as in urban areas. They also follow the cruel principle of early destruction of the fragile, female baby. We who mourn over the Gulf war and Srilankan genocide, have absolutely no problem in getting rid of these defenseless human beings. Female infanticide is practised widely in some States. Yet there is no law enacted against this specific crime.

III. Health and Nutritional Status of the Girl Child

III.1 Nutritional Status

Fortunately, some girls escape these death traps of selective abortion and female infanticide. Now at last we come to the question: What is the health status of these girls? What is their nutritional status? A girl is supposed to exist on anything. Even her cry to be fed and fondled is frowned upon, if not by her mother, at least by her relatives. Mother has no time to feed her, clothe her or

clean her. In one of the studies in Punjab, mothers were encouraged to breastfeed their children regularly both in upper and lower socio- economic groups. At the end of six months in both groups, about 90% of mothers achieved good nutritional status for their male infants, whereas only about 70% of mothers achieved good state of their nutrition for their female infants(1). Other studies also confirm that at any age, more girls suffer from malnutrition than the boys. It is more than proved that there is preferential treatment of males in Indian society and female children are neglected. The recording of nutritional status of children, attending Safdarjang Hospital, New Delhi, revealed that in infants, the severe form of malnutrition among males were 2.35%, whereas in females it was 18.35%. 56.67% of male infants were of normal nutrit ion whereas only 20.8% of female infants were normal(2). It was the same with toddlers and preschoolers. Yes, tiny as she is, the girl child is discriminated against, she is side-tracked, she is only at the periphery of family. This unequal distribution of food within the family becomes acute in distress situations like food and other disasters.

III.2 Adverse Female Sex Ratio

Perhaps because of the social inequality and injustice that majority of women were destined to suffer, the almighty God invested women with biological superiority. For some poorly understood reasons, women are biologically stronger than men. This biological superiority enables the girl child to survive against all odds. This fact accounts for higher female sex ratio that exists in many of the developed countries. In our own country, the State of Kerala also records higher female sex ratio. For, if all conditions are equal(social status, education, nutrition) female sex ratio will be higher at all ages. In contrast to this, in India, sex ratio of females is becoming alarmingly low. 1991 statistics forces us to hang our heads in shame (Ind. Exp. March 28,1991). What is the reason for the already low female sex ratio to be lower still, if not the continued neglect of the girl child from womb to tomb?

III.3 Mortality and Morbidity Rates

The policy makers and to some extent, the medical profession try to explain away this state of affairs by placing undue emphasis on maternal mortality. If the maternal mortality was the main cause of lower sex ratio in women, then the female/male ratio should have

been higher in female children. However, statistics have shown the contrary. Besides female foeticide and infanticide,there are other reasons for lower female sex ratio in various age groups before the reproductory period. The neglect the girls suffer and their lower nutriti onal status make them vulnerable to every type of infection and disease. Child mortality rate is 45 in males and 52 in females in the age group of 1-4 years. The higher death rate of female children persists in the age group of 5-9 and 10-14 years. Similarly morbidity rate is also higher in female in all age groups The biological superiority that she enjoys is tilted adversely because of low social status and gross neglect that a girl suffers.

III.4 Availability of Medical Services for Girls

Hospital admissions show that the percentage of girls admitted is only half that of the boys admitted for treatment. A study from Bangladesh showed that "despite nearly comparable incidence of diarrhoea in the village, male children under five years of age were brought more frequently than female children. In this study, the admission of boys for treatment was 66% higher than girls(3). India is not very different from Bangladesh in this aspect. A girl child is born to endure pain, neglect and insult. After all, values of self-sacri fice and self-denial have to be inculcated in girls if they are to be good mothers later on.

Medical profession also considers health of the woman important only in her reproductive age. Maternal health is important because of the child that is going to be born. She is to be fed and immunised, because of its influence on health of the new born. She has some rights and privileges only during her reproductory period. As a child, she can be neglected and discriminated against.

IV Low Social Status Affects her Education

The money spent on boys (health, education), is considered as productive investment whereas girls are considered not worth spending money for. This att itude accounts for the low literacy level of girls in our country. If we take rural population alone into consideration which comprises 70-75% of India's pop ulation, female literacy level is as low as 12-15%. Even of those girls who are sent to schools, 65% of them are stopped from going to school after their primary school education.

IV.1 Girl Child and Household Work

After primary school age, she disappears into the darkness of the home, to be dominated by the World of men. Yes, the girl child is brought up as though she is born and exists only in view of marriage and household work. By the age of 5-6, they fetch water and gather firewood. They look after their younger brothers and sisters. At the age of 5-9, girls' input of work is 79% higher than that of their brothers.

IV.2 Child Labour

Girl child would have been lucky if she was left alone with household work. It is not uncommon for little children of 5-6 years of age to be employed in match industry, beedi making, glass and bangle industry, carpet making and many other hazardous and dangerous occupation. Match industry and beedi making owners prefer girls rather than boys. Is it because they really care for the economic welfare of these girls? Far from it. The girls are used to boredom and routine humdrum of life. They are able to concentrate on minute, tedious details of work without a murmer of protest. Hence, the works that require precision, patience and perseverence are allotted to girls. Their tiny hands smoothen the match sticks, count them and arrange them, they make the boxes (which require deftness of fingers), paste labels and pack them. Boys are not expected to sit down and do such tedious work. They walk about and collect the finished products. They are also engaged in comparatively more prestigious work of dipping the sticks into the chemicals. (After all, without the little chemical, of what use is the match stick?).

IV.3 Health Hazards of These Occupations

Social activists and social workers from Sivakasi area report:

From the age of 9-10 onwards, the girls have no other choice except to be engaged in either match industry or beedi making. These girls are confined either to their homes or to the factory. They cannot breathe fresh air. Prevalence of tuberculosis is very high among these girls. They are up by 4.00 a.m. The pressure to earn money by putting in as much work as possible is so great, that they hardly stop their work to eat and to rest, resulting in malnutrition. In middle class families, the girls are harassed to do

more work and they are constantly reminded of the money they need to earn for their dowry. These children suffer from allergic skin diseases. Beedi rolling requires squatting in a particular posture for long stretch of periods. The growing bones of these girls are deformed. The pelvic deformities and consequent difficult childbirths have been reported.

Being confined to their homes or to the factories from very early age, they are emotionally starved. This, we are sure, is the cause of high incidence of hysteria and psychosomatic illnesses in these girls. In short, child labour causes these children to develop into physical (malnourished) and psychological dwarfs.

V Child Marriage

According to the law, no girl under 18 years is allowed to marry- A study in rural areas of Andhra Pradesh showed that even now the mean age of marriage is 13.7 years. The parents want to get rid of the girl as soon as she attains puberty. Totally unprepared, psychologically and physiologically, to shoulder the responsibilities of family life, their lives fall apart within a short period of time. Many of these girls are back in their parental homes within few months of their marriage. Reasons are many and well known. In any case, for all practical purposes, she has to live as a child widow when she is hardly 16 or 17 years of age. The worst tragedy is when their parents also keep nagging them for their fate. Then they may end up as refugees in cities or towns, or in desperation may even end their lives.

VI Premarital Pregnancies and the Fate of Girls

Unmarried girls aged 14 and 15 years becoming pregnant is common in the villages. Very often the parents of the concerned boy send him away to some far-off place to work and deny any involvement of their son in the matter. They threaten the family of the girl and blackmail them if they dare to accuse the boy. The girl is left with social stigma and is forced to abort her baby even at the 5th or 6th month of pregnancy. Apart from danger to her physical health and violence done to the baby, she suffers psychological trauma and even social ostracism. Many of them are condemned to remain unmarried for the rest of their lives. A few lucky ones are wed off at high cost.

VII Evils of Rape and Prostitution

We read frequently in the newspapers about gang rape and other such matters that we need not produce statistics and evidence here. There are reports, again from Andhra Pradesh, that the incidences of rape of girls are on the increase.

The year of tourism and promotion of tourism brings with it the evils of prostitution, especially that of children. The sexual violence that the girls suffer is part of the general violence that the women and children are subjected to. Authoritative and patriarchal ego of man uses these vulnerable groups of women and children as objects of his power and pleasure. It is not for him to bother about the consequences that they suffer or about their future.

VIII Why this State of Affairs?

All the woes and misery of the girl child that are listed above can be traced to one single cause: powerlessness of women. When nomadic man settled down to till the land, he realised that the land gave him sustenance as well as power. He usurped more and more land. He became the landlord. From then onwards, he 'lorded' over his household and all decision rested with him. The land and property was passed on only to the sons and to wife and daughters. The patriarchal society thus evolved, sanctioned a male dominated culture. Women did not possess any economic assets and neither she nor her work was considered to have any economic value.

This devaluation of woman affected every sphere of her life. She could not participate in public life nor assert her rights in sociopolitical matters. Cinema and advertisements exhibited mainly her sex role and cheapened her image to very low levels.

Laws are made and interpreted in the interest of man as was evident in laws of inheritance of property, marriage and divorce, labour and wages.

Religion and poetry glorified and ever deified women and her maternal qualities of self-sacrifice, of gentleness and compassion. Thus she was rendered harmless. She could not challenge or question man and his actions. In short, from time immemorial, society created a culture, a tradition in which woman was reduced to nothing but an object which was required for the function of reproduction and for cost-free domestic work. Is it any wonder then,

the girl child could be got rid of in the womb itself and if born, she could be treated as a thing which has no value.

IX What can we do for the Girl Child?

The only solution required is to give her, her rightful place in family and in society. Unless we give her basic human rights of equality and freedom, unless we are ready to accept woman as an equally important half of the humanity and reinstate her rights of land and property that rightly belongs to her, tackling of individual issues like malnutrition, morbidity, mortality, amniocentesis and S.D. tests will not be of much value. These efforts must be a part of the total activity i.e. creating a new culture where women are respected and valued.

Fortunately, women's organisation and groups are springing up all over the country. They have created a stir against injustice and oppression that the women suffer. Women can no longer be taken for granted. However, it is not enough for women alone to protest and fight for their rights. Creating a new culture requires a concerted effort of all enlightened and educated people. If we are willing, we who belong to the elite, professional group, can promote new value systems. We can help evolve a society which will treat girls and boys ali ke. Ley us hope that the day will not be far off when we can assure the girl child "you are equal to your brother".

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12. HEALTH OF THE FEMALE CHILD- PERSPECTIVES AND ISSUES

*Sudha Xirasagar * and Ashok Sahni**

I Introduction

Growing concern for the health and survival of the female child in the South Asian countries has led the group of SAARC to declare the decade of the nineties (1991-2000) as the Decade of the Female Child. There is increasing evidence of the social and cultural disadvantages of the female child from birth upto and into womanhood. Apart from the concern for the girl child's survival, is also the concern that the physical, emotional, social and cultural development of the girl child, profoundly influences her future physical and psycho-social role as a mother. Thus the health of the girl child has far reaching consequences into future generations. This paper presents the perspectives and issues with regard to health of the female child in India. It also makes recommendations towards promoting health of female children.

II Demographic Aspects

1. Female Child Population

Every year about 12 million female children are born in India. 25% of them do not survive till their fifteenth birthday and in fact 1.5 millions die before their first birthday(1). The population of female children (below 15 years of age) was about 132 millions in 1981, expected to be about 161 millions in 1991 and about 190 millions in 2001. Owing to adverse female child mortality factors, the sex ratio changed from 1116 for every 1000 males at birth, to 935 females for every 1000 males in the general population.

2. Mortality Patterns

The relative mortality of females compared to males in India is higher at all ages upto 50 years in contrast to the developed countries. This phenomenon is particularly marked in children, and more particularly in children under two years of age as shown in Table-1(1).

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In particular, considering the overall mortality (between 1955-1969 in the classical longitudnal Khanna Study) it was found that the female under-five child mortality rate was 74 per 1000 live births as compared with 50 per thousand for males. More recent studies show similar trends of mortality differentials.

Other significant observations are that, the phenomenon of relatively higher female child mortality is less pronounced in South India as compared with the North, and almost nil difference in female and male child mortality has been noted in Kerala (1,2)

Two significant developments in recent years have an influence on female child survival. The first relates to scientifically engineered female foeticide. Most published figures on mortality relate to mortality after fullterm birth and do not account for female foeticide. Recent developments of amniocentesis and ultrasound technology in prenatal sex determination have resulted in widespread female foeticide before birth in the metropolitan cities, large citi es and large towns in that order as well as increasing in popularity to smaller towns. This has been widely reported from the urban areas of northern India and particularly Bombay, during the last decade. Even slum women paying as much as Rs. 500/- to get early sex determination with the objective of female foeticide has been reported (3,4). An estimated 40,000 female foetuses were aborted in Bombay alone in 1984, out of an expected total of 1,27,000 female live births (@ 27.9 crude birth rate): This means that almost one-third of expected female births were averted by female foeticide. The demographic consequences, in case this practice becomes widespread all over the country, can well be imagin ed.

On the positive side, the second development relates to a welcome decline in male and female child mortality differentials observed in the ICDS project areas (5) as shown by an extensive study covering large number of projects from 1982 upto 1988.

III Socio-Cultural Problems of the Girl Child in India

The critical disadvantage facing the average female child in India can be summed up as, the denial of opportunity for physical, mental, emotional, social and educational development of the female child, which is accentuated by preferential suppression of the female child's opportunity in order to favour the male children. While the preferential disfavour to female children may not greatly

affect their physical and psychosocial development in the middle and high er income groups, the vast majority living in poverty or on the verge of povert y, suffer long term consequences as a result.

This disadvantage of the female child in India can be traced to two major factors. Firstly, the strongly entrenched patriarchical system in the society places greater value on sons as the instrument to maintain lineage, to ensure salvation to the parents after death, dependence of parents on sons for maintenance in oldage, male inheritence of property with the female children nowhere involved in the reckoning, concentration of economic power and assets with the males, a traditional right of polygamy for males, and lastly, a system where the females traditionally have no right of divorce or extramarital contacts. This results in low status of women, resulting in dependency of women on males for socio-cultural survival and lower value placed on female child survival and development, leading to casual or even deliberately neglectful attitudes in bringing up female children.

The second factor is related to the combined biological and indoctrinated commitment of woman as the mother to ensure physical and social survival of her offspring. This results in an obligatory dependency of women on the cultural institution of marriage and family, childbirth within marriage and commitme nt to ensure at all costs, the physical and social survival of the family. Whereas the social indoctrination and biological role of the father largely absolves the males of the commitment, even though they frequently undertake the economic responsibility of sustaining the family. One mentions "frequently" because in a substantial proportion of the poor urban and rural families as well as marginal families, women equally share or are wholly responsible for economic needs of the families, in addition to the biological and domestic role of child bearing, child rearing, food preparation, water supply and sanitation.

The above two critical factors compound one another leading to a situation of low status of the female child and very early indoctrination of female responsibility for the family system, leading to socially accepted pracitices of sacrificing the girl child's opportunity in order to provide greater opportunity to male children. The importance of these socio-cultural factors is indi rectly borne out by the sharp differences in the relative female child mortality between States of Uttar Pradesh, Punjab, etc., as compared with

Kerala. The northern States are characterized by deeply entrenched patriachical systems accompanied by low female literacy and skills for economic independence, and Kerala is characterized by substantial proportion of society having matriarchical lineage, high female literacy and educational status leading to greater visible economic productivity of women.

IV Health Problems of the Female Child

The health and developmental problems of the female child arise from relatively lower parental care and nutrition since birth to the average female child in India. The problems peculiar to female infants and children are discussed in the following paragraphs.

1. Nutritional Status

A large scale all India study conducted by the Central Technical Committee on ICDS during 1979-81 and during 1982-83 has shown that, of the severely malnourished children, 59.3% are females and 40.7% were males(5). The survey by the Registrar General of India on infant and child mortality and morbidity in 1979 showed that 22% of male children had Protein Caloric Malnutrition as compared with 34% of female children(6). Several studies have shown that the differentials in female and female child malnutrition vary greatly between the States for example in Punjab, a study by CARE showed that 71.43% of severely malnourished under five children were females and only 28.57% were males and that, of the normally nourished children, 69.2% were males and 30.8% were females. In Vellore area, the differentials were not so marked.

2. Morbidity Pattern

One of the most extensive morbidity surveys, on under-five children was reported from the Registrar Generals office in 1979(6). The observed morbidity pattern is presented in Table 4. It can be observed that specific deficiencies suggestive of lesser feeding of protective foods, was higher among female child dren, namely riboflavin deficiency, protein malnutrition, and iron deficiency. Overall the morbidity among female children was higher, particularly with respect to respiratory infections.

3. Child Care and Feeding

Corroborating the above findings and the higher mortality among female children, the following observations on child care and feeding practices are of concern. Several studies have confirmed that breast feeding is given more frequently and longer for male infants than females. Female children on the whole are weaned off the breast more quickly to promote an early pregnancy in anticipation of birth of a male child subsequently. Studies from the Registrar General have shown that these conclusions can be drawn even on demographic grounds namely, that a subsequent birth after the birth of female children is quicker than after the birth of male children, since the child is weaned off quickly resulting in earlier resumption of ovulation and pregnancy(1).

In depth studies (from Narangwal (Punjab) and several other studies) have shown that girl children were fed qualitatively poorer food compared with boys which was reflected in higher malnutrition rates and higher incidence of morbidity. These differences were less marked in the southern States(1,2).

4. Health and Medical Care

It has been repeatedly found that inspite of higher morbidity among female children, the proportion who are taken for medical care is far less. Prior to death, girl children had less frequently received medical attention than boys(2). Even though Kwashiorkar is three to five times as frequent in girls as in boys, hospitalization rates for Kwashiorkar of boys out numbered girls by fifty to one. Further girl children tended to have been treated by less qualified practitioners than boys. Table 5 shows the treatment pattern for ailing children in a classic study of 513 ailing male children and 730 female children in four rural communities, of different regions of India.

5. Demographic Consequences of Differential Morbidity and Care of Female Children

The above differences are reflected in the changing pattern of mortality from the neonatal period (when mortality is largely governed by biological factors) to the age of five, when the mortality pattern is increasingly moulded by sociocultural factors. A classic

longitudinal study in Narangwal, showed the mortality pattern with age and is presented in Table 6(1).

6. Education and Skills Development Opportunities

Another major area of concern is the wide differential between educational and skills development opportunities for female and male children. At the national level, the differentials in female and male literacy are not very high. The average literacy rate for the country as a whole was about 36.5% and for females it was 24%. Wide variations exist within the country particularly in the backward areas. There are 100 districts in the country (out of 440 districts)where female literacy is only 5-7% (7). Educational level of females is known to profoundly influence their future health and child care behaviour. Literate women, particularly better educated women, tend to seek antenatal care, avail the services of trained or qualified birth attendants, care for children better, practice birth spacing and family planning, resulting in better maternal and child health. Unfortunately, school dropout rate of girls is reported to be about 55% at the primary school level and 77% at the higher primary level (4). Opportunity for skills formation for better employment opportunities, tends to be curbed in case of girls (8). This results in obligatory employment of female children and adults in low skilled labour involving long hours of hard work and exploitation.

7. Child Marriage and Adolescent Pregnancy

Child marriage of female children below fourteen years leads to termination of educational and developmental opportunity together with risk of pregnancy which is extremely hazardous in early and mid teens. The emotional and psychosocial costs and premature responsibility of the child married early, are incalculable. It was found in the 1981 Census that the proportion of females married below fourteen in the country as a whole, is about 6.23%(9). Although the age at marriage is steadily going up, pockets of backwardness still exist. Four States, Bihar, Rajasthan, Madhya Pradesh and Uttar Pradesh account for almost 50 percent of girls married in the country before 16. These are also the States with lowest family planning practice, highest IMR and lowest female literacy (14). Rajasthan has particularly high incidence of child marriage. Child marriage is particularly common in the lower castes and particularly in conditions of poverty where it is linked to bride

price (10). Large proportion of child marriages are reported from districts with low female literacy and particularly the urban slums, eg. Madras (11).

8. Physical Abuse, Sexual Abuse and Prostitution

Physical abuse (violence) and sexual abuse of female children both at home and in the work place is increasingly coming to light. A study conducted by the Family Planning Association of India, Bombay, disclosed that 68 percent of women surveyed had been victims of sexual molestation(with or without actual rape) by an uncle or another male relative when they were children(12). System atic child sexual abuse is frequent in the workplace, especially in case of domestic serivice in urban areas.

Physical violence perpetrated, on female children is known to be more frequent than in male children even by parents. 8.5% of female children are estimated to be subject to neglect compared with 5% of males. Child prostitution is also very high. It is estimated that nearly 20% of the estimated two million prostitutes in India are minors below 18 years (15). Initiation into prostitution usually takes place at a very early age.

V Present Programmes and Policies for Health of the Female Child

Keeping in view some of the above factors affecting health of the female ch ild in India, the Government of India has introduced several legislations and programmes. The major legislations passed and under consideration are as follo ws:

i) Legislation on amniocentesis:

Legislation to forbid amniocentesis for sex determination has been passed by the Government of Maharashtra. A similar legislation is expected to be passed soon by the Government of India (13).

ii) Legislation on age at marriage:

The Child Marriages Restraint Act of 1978 prohibits marriage of girls below the age of 18.

iii) Legislation on prevention of child prostitution:

The Juvenile Justice Act (1986) and the Prevention of Immoral Traffic Act empower the authorities to remove children/minors from prostitution and place them under the care of the State(Juvenile care homes). It also provides for prosecution of adults responsible for these children.

iv) Legislation for regulation of child labour:

The Child Labour (Prohibition and Regulation) Act of 1986 prohibits employment of children below 14 in factories or workshops and the National Child Labour Policy directs the State to better coordinate and intensify income generation programmes in areas of concentration of child labour so as to minimise the economic need of families to send children to work.

v) Tne Integrated Child Development Services Scheme:

This is the most extensive and systematic programme for nutrition and child development, which has favourably influenced the nutritional status and mortality of the female child. It presently covers about 70% of the population.

vi) Creches for children of working mothers in rural areas and urban slums:

Under this scheme, the Government of India provides financial assistance to voluntary organizations for running creches to look after preschool children of agricultural woman workers and working slum mothers. Even though at present it is limited in coverage, if operationalized properly, it could indirectly lead to better school enrollment and educational opportunity for older female children by freeing them of the chore of baby sitting.

The above are some of the legislations and programmes aiming to maximize opportunity and minimize exploitation of the girl child. Several other legislations also exist such as the Abolition of Dowry Act. However, no legislation can alone achieve the objective, particularly, in matters of care of children, marriage and child opportunity. In these matters, any legislation requires a socio-cultural climate and attitudes of the people for effectiveness. In a climate where certain practices and attitude concerning the

female child are ingrained even among the law enforcing personnel politicians and health professionals, and in short, among the majority citizens of the society, it is difficult to expect mere legislation to succeed. Legislation is only the beginning for social action. Social action itself has to come from the society at large. For example, even though the Government of Maharashtra has long since banned sex determination tests and abortion to terminate female foetuses, a recent survey showed that of 8000 foetuses, 7999 were female (14). Hence, apart from legislations and policies, concrete programmes are required to change the social percept ion and values attached to a female child towards a more positive image.

VI Towards Health and Equity for the Female Child Future Directions

Keeping in view the above discussion on the female child, policies and programmes are required to catalyse the process of equity in health and social status of the female child. No doubt many indicators do show a gradual favourable change in the status and prospects of the female child and females in general. In the country as a whole, the average age of marriage has been increasing and better opportunities for female children are visibly available. However, as discussed in the paper, there remains a lot to be done and a long way to go yet, before the average female child in the country can be treated equal and feels equal to her male sibling in the family. Not only for egalitarian reasons but also in the interest of the national health and demographic scenario, there is urgent need to improve the social acceptance and nurture of the female child. The following summarize some of the approaches:

a) Strengthening the implementation of the ICDS programme and expansion to cover the whole country;

b) Action programmes to rapidly operationalize Mahila Mandals in most, if not all villages, through suitable training of functionaries of the ICDS, health, education and revenue departments, at grass root level, in community involvement.

c) Utilizing the Mahila Mandals for education of the community on issues of the girl child and female status.

d) Utilizing Mahila Mandals to plan and implement female (child and adult) literacy programmes, vocational training programmes for

female children relevant to the needs of the local area. This would improve the future economic product ivity of female children and thus improve the social perception of the female child.

e) Utilizing and encouraging the services of voluntary organizations to enable the government agencies to enforce the existing legislations, as also to create awareness in the community so as to encourage voluntary compliance by the community.

f) Modification of certain legislations and removing loopholes for better enf orcement.

g) Action programmes to orient law and order personnel and emphasise on working with the community for voluntary compliance rather than displaying an attitude of enforcement and prosecution.

h) Strengthening programmes which indirectly influence female child literacy, such as, the creche programme, and,

i) Strengthening the income generation programmes for women, in the rural are as.

VII Conclusion

In conclusion, the health and developmental status of the female child is of serious concern, not only on egalitarian grounds, but also in the interest of the physical and mental health and development of subsequent generatiions, which depends on the growth and development of the female child today. Also, the future family welfare scenario (and population growth rate) depends upon the health status, educational opportunity and status of the present day female child.

Mortality, morbidity and nutritional status continue to show wide differentials between male and female children with the figures skewed heavily against the female child, even though biologically, female infants and children are more equipped for survival than males. This is predominantly due to socio-cultural factors. Unfavourable feeding patterns right from birth, health care, nurture and attention to the female child, has resulted in relatively poorer chances of survival, education and, skills development in female children. This leads to the vicious cycle of low self and social image, and erosion of opportunity of survival in subsequent

generations. Apart from concerns of health and nutrition in infancy and childhood, female children face fresh burdens as they grow up. Child marriages and early pregnancy; premature personal, sexual and family responsibility; high risk of maternal death; permanent stunting of growth due to teenage pregnancy; sexual molestation at home and the work place, adds to their risk.

The ICDS programme is the single largest programme reported to have favourably influenced female child nutritional status and survival on a large scale. Apart from strengthening and expansion of this programme, strenghthening of the Creche scheme to take care of preschool children; operationalizing mahila mandals for grassroot level work in women's development; programmes for vocational training of girl children; income generation activities for women; involvement of voluntary organizations in community education, and operationalizing legislations for women's development; orientation of health, ICDS, education and law and order personnel in working with the community on girl child issues,are some of the suggested future directions towards promoting health and survival of the female child in India.

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Table 1
Ratio of Age Specific Mortality Rates of
Males to Age Specific Mortality Rates of Females

Age (in years)	1951	1961	1971	1987 SRS
0	1.09	1.11	1.04	
1	0.76	0.83	0.84	
2	0.74	0.83	0.73	0.91
3	0.76	0.82	0.76	
4	0.80	0.82	0.83	
5	0.83	0.81	0.74	
6	0.86	0.81	0.73	
7	0.89	0.81	0.73	0.72
8	0.92	NA	0.74	
9	0.96	0.83	0.81	

Table - 2
Sex-wise Mortality Rates of Children in ICDS areas
(Study in 1982 - 83)

		Infant Mortality Rate	
		Male	Female
(i)	Rural ICDS Projects	88.4	86.4
(ii)	Tribal ICDS Projects	98.7	87.8
(iii)	Urban Slums	88.9	61.2
	Total	90.8	77.4

Source: Central Technical Committee on ICDS (1990)

Table - 3
Sex-Specific Death rates/1000 0-4 aged population

	Death Rates 0 - 4 years	
	Male	Female
ICDS Areas	21.3	19.8
SRS Estimates (Gen. Population)	37.9	40.5
% Reduction in ICDS	43.8%	51.2%

Table 4
Morbidity Pattern of Children-Sexwise(6)
(in percent)

Disease	Male	Female
Riboflavin deficiency	30.4	35.4
Iron Deficiency	29.9	33.5
Respiratory Infections	27.3	55.5
Protein Calorie Malnutrition	22.2	34
Vitamin A Deficiency	22.7	22.2
Skin Diseases	18.8	18.7
Gastro-intestinal disorder	27.2	29.9
Dental Caries	14.8	9.0
Ear disease	5.7	6.9
Vitamin-B Deficiency	1.7	2.7
Headache	0.6	1.4
Throat Infections	0.1	1.1
Allergic Reactions	0.6	1.4
Nervous Disorders	Nil	1.4

Table 5

Percentage distribution of ailing male and female children in four different geographical areas*

	Area 1		Area 2		Area 3		Area 4	
	M	F	M	F	M	F	M	F
No treatment	30.8	58.1	18.7	62.1	13.0	27.8	7.6	16.0
Treated free	3.8	2.3	3.7	3.1	19.5	27.2	4.2	2.3
Household treatment	15.4	16.3	54.2	19.2	8.9	9.4	29.2	28.0

* Study by Dandekar (1957) as quoted by Ghosh, Shanti in (1)

Table 6

Births	Male	Female
Births	1560	1415
Still-births	82/1000	51/1000
Perinatal deaths	90.1/1000	73/1000
1-7 days deaths	41/1000	40.3/1000
1-29 days deaths	55.1/1000	65/1000
1 month - 1 year	34.6/1000	55.1/1000
Infant mortality	89.7/1000	120.1/1000
1 year - 2.9 years	9/1000	16.8/1000

13. NUTRITIONAL STATUS, MORBIDITY AND MORTALITY AMONG FEMALE CHILDREN

(A SUMMARY)

*Umesh Kapil**

The average female in India faces negative bias from birth until her death and of late, even before birth. The manifestations of the social and family bias against females include, female foeticide, female infanticide, relative neglect of the female infant with regard to feeding and child care, early weaning even in rural areas to promote early subsequent conception(hopefully of a male child) and, neglect in terms of opportunities for nutrition education and deve lopment.

Most of the female children and mothers' contribution to the family economy and survival is unaccounted and ignored, when it comes to considering females as a liability. In India, it has been estimated that 45% of the agricultural work is done by women, and of this, more than 20% is shared by girl children. This is apart from the contribution at home in feeding the family and maintaining sanitation, water and fuel supply, care of younger children, etc. It is estimated that the average girl child in rural India works for 9 hours a day for 315 days of the year (in the fields and at home) which would have cost Rs.2,000/- (at minimum wage rates) to hire. In spite of this contribution, the girl child suffers neglect discrimination, poor social image, and finally low self-image. One of the major reasons for this is low self and social awareness of the self-worth, and large scale female illiteracy.

Keeping in view these factors the following measures have been suggested for improving health of the female child.

1. All grass-root level programmes such as the Integrated Rural Development Programme (IRDP); Training of Rural Youth for Self-Employment (TRYSEM), etc should explicitly have specific components for improving health, nutritional status and literacy of girl children in their area of operations.

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2. Secondary school education curriculum should have the component of sex educ ation and family life.

3. General awareness should be created through mass media about the positive aspects of the girl child.

4. Strict enforcement of laws which help in safe motherhood and equal remunera tion for females such as, Child Marriage Restraint Act of 1978, Equal Remunerat ion Act 1975, etc.

5. Promotion of fuel and drinking water availability within easy distance of habitations.

6. Free secondary education for girls, free uniforms, text books and other inc entives can be provided for girls.

7. Schools could be upgraded to provide vocational training to girls after matriculation or school dropout.

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14. A STUDY OF ADOLESCENT GIRLS IN THE SLUMS OF BOMBAY

Regina Baretto, Madhu Parmar*, Vidhya Lad*, Sr Kusum* and Ancilla Tragler**

I Introduction

The year 1990 was declared as 'Year of the Girl Child' which inspired our community health team to concentrate on the adolescent girl in the slum and her problems. The adolescent period for girls is critical for several obvious reasons:-

1. The adolescent girl is curious about her reproductive biology and hence she would be more receptive regarding health education.

2. The second growth spurt at puberty together with physical changes that takes place in a girl makes her more vulnerable to health problems.

3. It is an ideal time before responsibilities begin to give her a training for family life education.

4. This is also a phase of not only physical growth, but mental development and that is why inputs like self image, decision making etc. are important aspects for the adolescent girl.

5. Functional literacy to include training for income generating skills and regarding socio legal issues can have its best impact at this time.

Keeping the above in mind the following study was done in the urban slums included in our Community Health Programme in Bandra, a suburb of Bombay. There is lack of data regarding the adolescent girls in the slums and her proble ms. After evaluation of the baseline survey data we hope to evolve an integra ted approach to the betterment of the adolescent girls in the slums.

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II Methodology

The study included adolescent girls ranging from age 11 to 18 in 284 families with population of 1505 living in Jafferbaba slums. Initially, we had started informal youth gatherings for the girls to evolve an approach to their problem. We found these weekly meetings were well attended as the sessions were made interesting and lively with discussions and games. Gradually, as we got to know the girls better, we conducted a survey to obtain baseline data regarding their problems and life style. A pretested interview schedule was used and data was collected on socioeconomic, educational and cultural status, religion and moral values. Their daily activities, skills, health knowledge and problems, awareness of legal and social issues and their aspirations were also studi ed.

There were 85 girls in the families covered, of these 80 girls took part in the study, while five declined to take part. The study was conducted by trained members of our community health team. All the girls had general medical checkup which also included haemoglobin estimation.

III Results

III.1 Profile of the Study Population

The study included 80 girls of which 38(48%) were between 11 to 13 years, 19 (24%) were between 14 to 16 years and 23 (29%) were between 17 to 18 years. 52(65%) of the girls were students, of whom 28 (54%) were in 5th to 8th Standa rd, 20(38%) were in 9th to 10th, and four (8%) were in college.

Of the 80 girls, 20(25%) were dropouts from school. 8(10%) never registered for school. The reasons given for failure to enter school were, either long distance of school from their native village in case of four girls, or constant migration of family. Five of the twenty dropouts were dropouts from primary schools, 15 (75%) of the dropouts were from secondary school. Reasons for dropout included, economic factors 8(28%), household responsibilities - 7 (25%) and parental attitudes - 13(47%). (Table - 1). Of the families of the 28 girls which included both dropouts and illterate, boys in the family had however continued their studies in case of 24 families (85%). On interviewing parents, the actual reason for failure to register the girls to school was the parental attitudes (50%)

and household responsibilities (50%). Both dropouts and those who failed to enter school were interested in literacy classes.

III.2 Working Girls

The 28 girls who had dropped out of school were working. Among the girls who were schooling, one girl together with studies helped her mother who was a domestic worker.25(89%) of the 28 working girls were working as domestic workers, and two (8%) were helpers in nursery, and one (3%) worked in a beauty parlour. The girls worked for various periods which included two hours(six girls), four hours (seven girls),six hours (eight girls), eight hours(four girls) and late night (three girls). Their income varied from Rs. 100/- to Rs.400/- per month i.e. three girls earned Rs.100/-; Rs.200/- six girls, Rs.300/-eleven girls and, Rs.400/-eight girls.(Table 2).

III.3 Daily Activities

Most of the girls contributed to the housework and did various jobs, like washing 73 (91%) cooking 67(84%), cleaning 33(41%), and marketing 19(24%), looking after siblings 7(9%). They spent their free time, in reading 30 (38%), in watching T.V. 43(54%), handicrafts- eight(10%), games-five(6%). Their habits included, eating sweets 29(37%), chewing pan 5(6%), chewing gum 14 (18%). There was no admission of drug abuse or alcoholism. Their skills included, cooking 54 (68%), tailoring and embroidery 34 (43%), painting 8(10%), Ironing 17 (22%), handicrafts 25(31%). Very few of the girls had travelled outside Bombay (26%) most of these only to their village.

III.4 Socio Economic Status

Socioeconomic status of the families showed that most of the families were in the low income group-35(44%) had incomes less than Rs.800/-per month, 35(44%) families had incomes less than Rs. 1000/- per month and 10(12%) had incomes more than Rs. 1500/-. 24(30%) of the mothers were illiterate and 11(14%) of the fathers were also illiterate. The average family size was 5.3. Most of the girls had one to four siblings which included a male, except in two cases. 37(46%) of the girls mothers were working as domestic workers. Their religious and geographic background showed that 30(37%) were Hindus of Maharashtra 34(43%) Christians, nine

(11%) Hindus of U.P, four (5%) were Buddhist, and three (4%) were Muslims.

III.5 Health Knowledge and Problems

The girls were questioned for their knowledge of health and hygiene. Seven (9%) knew about hygiene; causes of disease like Tuberculosis 14(17%) and Tetanus 7(9%); types of immunization nine(11%); causes of menstruation three (3%);balanced diet 31(38%); child nutrition 38(47%); home treatment for diarrhoea 31(39%) and, appropriate age for pregnancy 46(57%).

Their complaints and health problems included, respiratory problems 15%, gastro-intestinal 14%, menstrual 47%, general weakness 28%, caries 72%, Vitamin deficiency 25%, Skin problem 35%, worm infestation 33%, lice 69%, underweight 38%, anemia 48%, others 13%. The haemoglobin estimation revealed that 9% were below 9 grams 39% between 10-11 grams, and, 52% were 12 grams and above.

III.6 Choices

These adolescent girls' idea and aims of a better life included, better clothes 23%, better food 23%, housing 30%, money 39%, better health 45%, entertainment 20%, better education 23%, employment 19%, better friendship 8% and better family 9%.

III.7 Social Issues

Regarding awareness of social issues, 54% of the girls thought that marriage was essential, 82% girls were in favour of arranged marriage, 78% of them were not in favour of dowry, 65% of them were aware that girls had a right to property. Most of the girls were in favour of small families with almost equal number of girls and boys. The girls visualised the role of woman in marriage mainly as shouldering household responsibilities 95%, child bearing 54% and earning capacity 35%. The role of man in marriage was seen to be mainly in terms of earning capacity 92%, household responsibilities 34%, and care of family 10%.

58% of the girls were not allowed to speak to boys and only 25% of the girls admitted to having some friends who were boys. The qualities essential for a girl were thought to be, honesty 59%, hard

work 26% and courage 41%, while the qualities considered for the boys were, hard work 82%, honesty 17% and courage 14%.

III.8 *Awareness of Exploitation*

Regarding awareness of exploitatioin, 48% of the girls were aware of rape, 54% aware of physical abuse, 6% aware of prostitution, and 20% aware of unequal opportunity for girls. Taking into consideration their own life situation, 23% of the girls admitted to having unequal opportunity in education, 15% in respect of clothes, 7% in respect of food and 9% in respect of affection. Althou gh most of the girls did a large share of the household work, only 14% expressed that they have more work than their brothers. 11% of the girls had experienced eveteasing, 15% physical molestation and 4% mental torture.

IV Discussion and Recommendations

There is an urgent need to tackle the problems of adolescent girls in our cou ntry. In this study, the problems of adolescent girls stand out against the well known detrimental factors of slum life, i.e. poverty, over-crowding, lack of housing, sanitation and poor hygienic environment. The major problems which emerged from the study, was failure of the girls to go to school (35%). The reason was chiefly due to discriminative parental attitude towards girls, resulting in them having increased household responsibilities and also having to work outside. 85% of these families had allowed their sons to continue studies. Inspite of large percentage of the girls (65%) going to school, health awareness was lacking. The girls were also not sufficiently aware of their own exploitation in the areas of education and work. Most of the girls maintained the traditional attitude of acceptance of girls having to do more household work. Major health problems in these girls were, poor nutritional status, anaemia, caries, vitamin deficiency and worm infestation. Girls (53.75%) spend their free time watching T.V. which may have made a positive impact on their knowledge. Yet it did not have sufficient impact due to entertainment programmes being given priority.

Some positive trends of the study were that the girls were against dowry, they were in a favour of small families, had some creative skills, were in favour of hard work. Their priorities in life were housing, education, employment and health. Only a small percentage of them admitted to have been abused. The girls also

had hopes and aspirations for a better future, which should not be denied to them by society.

Based on the above data we can now work towards an integrated approach to the adolescent girl in the slum and her problems together with parental and community involvement. However, in order to make an impact on the problems of adolescent girls a mass social movement is required. The waves of social awareness and action should spread to involve larger groups, community at large and the whole country., only then will the future be bright for adolescent girls.

V Summary

This study was done to find out baseline data about the adolescent girls in the slums, and then to evolve strategies for their betterment. The study showed the major problem to be failure to go to school, increased household respon sibilities, poor health and social awareness. Majority of boys in the same families were not dropouts, or failures to enter school, hence parental attitudes is the main reason for the failure of girls to go to school. Girls were also found to have problems of anaemia, underweight, vitamin deficiency and caries. Girls were in favour of small families, were against dowry, had some creative skills and only a small percentage of them admitted to abuse. The girls also had hopes for a better future which can be fulfilled with integrated social action.

Table :1
Reasons for not going to School

	Economic		Unfavourable Parental Attitude		Household Responsibility	
Dropouts - 20	No	%	No	%	No	%
	8	28	13	47	7	25
Failure to enter school-8	-	-	4	50	4	50

Table : 2
Working Girls Profile (Total - 28 girls)

	Domestic		Nursery		Helpers		Beauticians	
	No	%	No		%		No	%
a. Type of Work	25	89	2		8		1	3
b . Hours of Work	2 hrs.		4 hrs.		6 hrs.		8 hrs.	Late night
	No	%	No	%	No	%	No %	No %
	6	22	7	25	8	29	4 14	3 10
c. Income earned	Rs.100/-		Rs.200/-		Rs.300/-		Rs.400/-	
	No	%	No	%	No	%	No %	
	3	10	6	22	11	40	8 28	

Table: 3
Knowledge of Health and Hygiene

Hygiene		Causes of tuber-culosis		Causes of teta-nus		Types immuni-sation		Causes of men-struation		Balan-ced diet		Child Nutri-tion		Home treat-ment		Pregn-ancy	
No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
7	9	14	17	7	9	9	11	3	3	31	38	38	47	31	39	46	57

Table :4
Health Problems %

Respiratory	15
Gastro-intestinal	14
General Weakness	28
Dysmenorheoa	47
Caries	72
Vitamin deficiency	25
Skin problem	25
Lice	69
Worm infestation	33
Underweight	38
Anaemia	48
Other	13

Table 5:
Choices for Better Life %

Clothes	23
Food	23
House	30
Money	39
Health	45
Entertainment	20
Education	23
Employment	19
Friendship	8
Family	9

Table 6
Awareness of Social Issues %

a.	Marriage Essential - yes	54	g.	Role of Women in Marriage	
b.	Arranged Marriage	82		i) Household responsibilities	95
c.	Love Marriage	18		ii) Child bearing	54
d.	Dowry not good	78		iii) Earning	35
e.	Awareness of Girls right for family poperty	65			
f.	Preference for number of Children		h.	Role of Husband in Marriage	
	1 - 2 children	68		i) Earning	92
	3 - 4 children	32		ii) Household responsibilities	34
	Girls -yes, would like to have	93		iii) Care of family	10
	Boys - yes, would like to have	96			

Table 7:
Exploitation and Inequities of Opportunity of Girls %

1.	Awareness of exploitation	Rape	Physical	Prostitution		Unequal Opportunity
		48	54	6		20
2.	Experienced Unequal Opportunity	Education	Clothes	Food	Work	Affection
		23	15	7	14	9
3.	Experienced Abuse	Eve Teasing	Physical molestation		Rape	Mental Torture
		11	15		-	4

15. HEALTH CARE OF THE YOUNG SOLDIER IN INDIA

*Brigadier D P Achar**

I Introduction

'Health care' today entails a very substantial and broadbased spectrum of personal health serivices, ranging from health education through information and communication, to providing affordable means of health promotion, prevention of disease, early diagnosis, treatment and rehabilitation within the limits of social and economic ability of the individual and the community. During the past two decades, there has been a great change in the social values and more stress has been laid on improvement of the physical quality of life of the community regardless of its socio economic structure.

The Armed Forces in India have undergone a great deal of modernisation in tune with the tremendous advances in military technology. However, the man behind the machine is still the vital, decisive factor. People all over the country in general, and those in the Armed Forces in particular, seek higher standards of living and are conscious of their rights. Provision of essential health care and other basic amenities has therefore become a social responsibility and obligation to the community. The Armed Forces are a leading force in this direction.

Ever since inception, the Armed Forces Medical Services in India have been striving to provide primary health care for all members of the Armed Forces, more particularly the young soldier. The medical men themselves have to perform a much bigger role than their civilian counterparts, as they are identified both as doctors and soldiers. Services are integrated to provide preventive, promotive curative and rehabilitative care in two totally different, contradictory scenarios - war and peace. At the same time, these services are provided at the remotest of the places varying from the depths of the ocean to the icy heights of the Siachen, or from the burning deserts of Rajasthan to the marshy jungles of the eastern sector. Not only the young soldier and his family but also his dependant parents are now entitled to medical care by the military medical serivices.

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The primary aim of medical services in the Armed Forces has been to keep the young soldier not merely physically fit, but fighting fit, physically, mentally and socially. The objective is to maintain a constant state of positive health, protecting him from specific identifiable risks, with an emphasis on quick diagnosis and treatment so as to put him back on duty with least loss of man hours. Ours being a relatively young Army, the necessity of comprehensive health care of the young soldier in an integrated manner becomes most relevant.

II Concept of Primary Health Care in the Armed Forces

The Armed Forces follow the pattern of three tier system of medical care as advocated in the concept of Primary Health Care. A special emphasis is laid on an important ingredient of this concept, namely, the first contact care. This is provided by the Regimental Medical Officer, who is posted on the strength of the fighting body of troops- Infantry, Artillery, Armoured Corps etc. The Medical Corps is the only service which works in such close contact with the combat forces. The RMO learns the socio-cultural pattern of the troops,the special problems they face, and by participating in all their activities, is accepted by the men as part of them. It is this feeling of oneness that enables him to understand their 'pulse'and he is able to provide them total health care by adopting an integrated and multisectoral approach. With this kind of contact, the impact of health education and motivation is great. It is therefore not surprising that the knowledge, attitude and practice of the young soldier towards healthy life style is much more and much better than his civilian counterpart. As a result of permanent contact with the young soldier, the military physician finds himself at the forefront of the battle against diseases.

The intermediate level of care is provided at various military hospitals and field medical units, with advanced specialist care at Zonal/Command Hospitals, Cardio Thoracic Centre and so on. The Artificial Limb Centre provides tertiary level of care. These establishments are fully equipped with adequate staff and sophisticated equipment. The chain of evacuation of the sick and wounded is closely linked with the system of referral both in war and peace, incorporating the land, sea and air evacuation of casualties.

III Vulnerability of the Young Soldier

A noteworthy factor is that, not only the young soldier is at the peak of his youth but at the same time, he is highly vulnerable because of the very nature of his profession. He hails from different, divergent ethnic, social, cul tural, religious and educational backgrounds, and belongs to different geographical and climatic areas with varied life style of his unbringing. As a recruit and young soldier, he is exposed to the sudden, harsh and often unknown stresses and strains of military life, which make him at once vulnerable. In the event of war or a major catastrophe, the need to act under extreme time pressure and imminent external danger will make the situation all the more risky, especially when hygienic and environmental conditions are far from optimal. The kinds of contingencies the young soldier must be prepared for during war conditions are endless. Service in the military compels him to change his way of life radically. In such situation, he passes through multiple physical, mental and social stresses in different climatic and geographical environments to which he is not accustomed. In any case, whatever the adverse circumstances of military life, he has to be alert enough to handle his weapon effectively. Often unmarried and away from home, separated from his near and dear ones and in the prime of sexual activity, there is a risk of elevated promiscuity, which,in turn, is likely to involve high - risk partners - promiscuous youth and prostitutes. Duty close to large cities and high risk areas enhances the threat. Because of his constant mobility, he is at risk of picking up infections from high risk endemic areas. The impact of infections on the uniformed forces can be considerable because of the very nature of their life style - collective, group living in common barracks, eating under common kitchen and performing activities in groups. The sick soldier is often a liability to his job/equipment and vice versa. It is precisely for this reason that he is required to be kept at the peak of his health at all times, under all situations - be it war or peace, de sert or the deep sea, high altitude or the plains. Public attitudes towards the military - including the willingness to apply for military duty and the general estimation - will, in the long term, depend upon the degree of success of the military in dealing with these problems.

IV Levels of Prevention

All the three levels of prevention are actively practiced in the Armed Forces. The greatest emphasis however is on primary prevention which is the sheet anchor in the maintenance of health

of the young soldier. Health promotion activities include compulsory Physicial Training(PT), games and sports, parades and drills. These build up their physical proficiency and enhance their Battle Physical Efficiency Tests, which are compulsory. Good food provided as free rations both in war and peace times, ensures positive nutritional balance far sup erior to his civilian counterpart. Free clothing suitable to the climatic environment provides optimal conditions of effective thermal comfort. Environmental hygiene and sanitation is constantly monitored to watch for adverse effects. Religious, cultural and recreational acitivities go hand in hand to meet his so cial, emotional/mental health needs as is his entitlement of three months leave every year to rest, relax and recoup.

Information, Education and Communication is the backbone of health education in the Armed Forces. The young soldier gets it through daily roll calls, orderly rooms, information/recreation rooms, and monthly sainik sammelans, in addition to the frequent discourse by his superiors and talks by the medical officers. This has largely contiributed to the motivation of the young soldier and improvement of his knowledge, attitude and practice towards a healthier life style. It also provides the necessary base and impetus for his accountability in maintenance of his own health, as much as in other military matters, especially in respect of preventable diseases.

The specific protections for the soldier include immunizations, compulsory use of crash helmets, protection against hot and cold weathers, snow-bound, high altitude areas and such other personal protective measures as in the case of malaria.

Regular, periodic medical examination ensures secondary prevention in the form of early detection and prompt treatment. Special significance is attached to the medical inspection of troops proceeding to hazardous areas such as high altitude areas. As regards tertiary level of prevention, the disabled young soldier is never allowed to beocome a destitute. Handicapped soldiers are treated in specialised centres- Artificial Limb Centre, Paraplegic Home,Queen Mary's Technical School etc where vocational training is imparted. The disabled soldier gets liberal pensionary benefits. Army Group Insurance Scheme also provides adequate relief. In addition, a number of jobs are reserved and offered both in public and private sectors. Thus, there is a good deal of social security

system in operation, which helps him get over his disability by optimum utilisa tion of his residual abilities.

Dental health care is given equal importance with regular, periodic dental examinations to keep the soldier biting fit.

V Conclusion

The Armed Forces Medical Services have been integrated with other Armed Forces Establishments to provide comprehensive health care to the military community in general, and the young soldier in particular, with the twin objectives of prevention of disease and promotion of positive health. Simultaneous attention to both physical, mental and social health keeps the soldier fighting fit in all situations.

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16. AN OUT-PATIENT ANALYSIS OF HEALTH PROBLEMS OF THE YOUTH

*G.Bala Ganesh *, Anandeep Kumar* and V.Chandrasekhar**

I Introduction

The youth, 15 - 25 years age group (W.H.O), are an extremely important group because they are on the threshold of shouldering the various responsibilities of the community. They are tomorrow's adults and as much an extremely important human resource. This study was undertaken to study the nature of health problems of youth.

II Objectives of the Study

1. To study the health problems of youth attending our hospital OPD at given point of time.

2. To understand, as far as possible, whether the health problems which occur are specific to young age (youth).

III Material and Methods

A pretested, semistructured schedule was administered to the selected patients. The youth were studied from different O.P.D's over a period of 20 days. After a random selectiion of O.P.d'S, the patients too were randomly selected. The schedules were administered to all the selected youth.

IV Results

70 youth from among the outpatients of SV Medical College Hospital, were selected through multiphasic random sampling studied regarding their socio-economic status and health problems. Out of 70, 46(65.71%) were males and the remaining 24(34.29%) were females, 36 (51.43%) of them were in 15-20 years age group and the remaining 34 (48.57%) were in 21-25 years age group. 45 (64.28%) came from nuclear families, while the remaining 25(35.72%) came from ioint families. This is probably because they are from urban area.

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Regarding the education of the parents of the youth, the following is observed. 35(47.14%) had illiterate fathers/ guardians. 23(32.86%) fathers were educated upto primary level. 13(18.54%) fathers were educated upto secondary level. Only one father (1.43%) of a woman was educated upto tertiary level.

Regarding the occupation of the parents, the following is observed. 51 (72.86%) of the parents were working as labourers. 13(18.57%) were engaged in skilled labour, 5(8.57%) were doing clerical jobs. Only one (1.43%) father was doing managerial job.

Regarding the income of the parents, 34(48.57%) parents were earning less than Rs. 500 per month. 32 (45.71%) were earning Rs.500- 1500/- per month. Only 4(5.71%) had income more than Rs.1500/- per month. This shows that about 90% come from poor families. This also is consistent with low socioeconomic state.

Educational status of the youth showed that 20(28.57%) were illiterates,28 (40%) were educated upto primary level, 22(31.43%) were educated upto secondary level. None of them was educated beyond se-condary level.

It is interesting to note that 21.74% of boys are illiterate compared to 41.67% girls. Again among the literates, more boys are educated than girls. This goes with the popular opinion that more men are literate than women in our country. The averages may be less than the averages of census, 1991, but they do indicate the inferior status of girls in our country.

The nutritional status of the youth was assessed based on clinical appearance. Accor ding to this, only 15(21.43%) were considered malnourished.

The youth were studied from the out-patient departments of Medicine, Orthopaedics, Casualty, S.T.D.,TB & Chest Diseases, Gynae-Obstetrics, Psychiatry and Skin which were randomly selected. Majority (24.29%) came with medical problems, followed by psychiatric problems,skin, Orthopaedics, Gynaecology, etc. The number of male youth was usually greater than that of the families. It is interes ting to note that none of the girls came to S.T.D. Department. This is probably because males feel more free to come, and women's problems are not given priority due to their inferior status.

Regarding the health care given to them, the following is observed. 32(69. 57%) men were admitted, and the rest treated in the O.P.D.itself. Among the girls 20(83.33%) were admitted while the remaining were not admitted.

Next the behavioural problems were specifically studied, as they are youth. All the behavioural problems were observed to be greater among men. None of the women admitted drinking alcohol or exposure to STD. The greatest vice was smoking, which was seen in 33(71.74%) males and even in 2 females (8.33%). Even mental stress was seen more in men, 27(58.7%) than in 19(41.3%) women. It appears that our traditions and culture are shielding our young women better than our young men. *It may be noted that almost 20% of male youth gave a history suggestive of exposure to STD.*

Regarding the morbidity pattern, the following was observed. 31(44.28%) were suffering from infectious diseases, whereas 39(55.72%) are suffering from noninfectious diseases. The proportion of noninfectious diseases was higher. This is probably because of greater resistance due to youth.

The 70 youth came with various health problems which are indicated in Tab le 2.

B.B. Tripathy etc. al (1979) observed in their study in Orissa that 1.4% were suffering from Diabetes. In our study we also found that 1.43% were suffering from Diabetes. The infectious diseases were about the same in both sexes and they accounted for 12.86%. Mental illnesses accounted for 17.14% (12). Again more men (10 or 21.17%) than women (2 or 8.3%) came for mental illnesses.

S.T.D. was seen only in 7 men 15.21%. None of the women came for this. This is probably because majority of our women are not yet married, as they are from urban areas. Also boys feel less shy to come for STD than girls.

Regarding the accidents and injuries, they accounted for 11.43%. Significantly, more men than women, 13.04%; and 8.33% came with these problems. The picture regarding the skin diseases was similar.

High risk pregnancy accounted for almost all the women that came to obstetric O.P.(8/9). They constitute 33.3% total female patients. The incidence of heart disease in pregnancy was 1.43%. K.K. Talwan et.al (1979) observed (Ref.6) heart disease in pregnancy as follows:

Calcutta - 0.45%, Bombay - 0.2%, Visakhapatnam -0.72% and Chandigarh - 0.9%. In our study, the heart problem was found slightly higher, probably because our sample was not large.

Lastly the problem whether it was specific to youth was also studied by asking the question to the respondents and by estimating based on current disease theories. 47(67.14%) of them were suffering from the problem because they were youth. Sex-wise, 65.22% among men and 70.83% among women were suffering because of their youth. This is a very significant observation.

Conclusions

Among the youth, majority of them were suffering because they were youth. Many problems are seen significantly higher in males. Especially the behavioural problems were seen more in males.

In the hospital administration, the problems seen are, under-staffing, overcrowding, inadequate materials etc. These problems have been severely hamperi ng the administration in our hospitals.

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Table 1:
Departments Attended by the Youth

S.No.	Name of the Department	Male	Female	Total
1.	Medicine	8	9	17 (24.29%)
2.	Orthopaedics	8	1	9 (12.86%)
3.	Casualty	2	0	2 (2.86%)
4.	S.T.D	7	0	7 (10.0%)
5.	TB & Chest Diseases	6	1	7 (10.0%)
6.	Gynae. & Obst.	-	9	9 (12.10%)
7.	Psychiatry	8	2	10 (14.29%)
8.	Dermatology	7	2	9 (12.86%)
	Total	46	24	n = 70

Table 2:
Behavioural Problems

Sl No	Problem	Males n= 46		Females n= 24		Total n= 70	
		Yes	No	Yes	No	Yes	No
1.	Smoking	33 71.74%	13 28.26%	2 8.33%	22 91.67%	35 50%	35 10%
2.	Alcohol	22 47.82%	24 52.18%	- -	24 100%	22 31.43%	48 68.57%
3.	Mental stress	27 58.7%	19 41.3%	10 41.67%	14 58.33%	37 52.86%	33 47.14%
4.	Drug abuse	11 23.91%	35 76.09%	1 4.17%	23 95.83%	12 17.14%	58 82.86%
5.	Exosure to STD	9 19.56%	37 80.44%	-	24 100%	9 12.86%	61 87.14%

Table 3:
Morbidity Pattern in the Youth

SL.No.	Disease	Males(n= 46)	Females(n= 24)	Total(n= 70)
1.	Medical - Resp. GIT,etc	8 (17.39%)	9 (37.50%)	17 (24.28%)
2.	Infections diseases TB, Leprosy	6 (13.04%)	3 (12.5%)	9 (12.86%)
3.	Mental Illness	10 (21.17%)	2 (8.33%)	12 (17.14%)
4.	S.T.D.	7 (15.21%)	0	7 (10.0%)
5.	Accidents & injuries, etc	6 (13.04%)	2 (8.33%)	8 (11.43%)
6.	Skin, Scabies, eczema, etc	6 (13.04%)	2 (8.33%)	8 (11.43%)
7.	High risk pregnancy	- -	8 (33.33%)	- -

Table 4
Whether Youth Problem

Sl. No.	Is the problem because of youth	Males n = 46	Females n= 24	Total n= 70
1.	Yes	30(65.22%)	7(70.83%)	47(67.14%)
2.	No	16(34.73%)	7(29.17%)	23(32.86%)

17. HEALTH BENEFITS OF ADULT EDUCATION IN K.V.KUPPAM BLOCK, TAMILNADU

Florence Jabamani Selvakumari , Devasahayam* and*

*Rajaratnam Abel**

I Introduction

Literacy and development are interrelated. Illiteracy forms a part of the vicious cycle with poverty which is the result of the existing socio-economic inequalities in a developing country. Any attempt to reduce illiteracy can become an instrument of social and economic development, leading to the desired structrual changes. Adult education plays a vital role in this direction with sufficient opportunity for peoples' involvement in solving their own problems, either at the individual, familial and/or community level. The National Adult Education Programmes was formally started in October 1978 with the main aim of providing more information, better knowledge and skills to the adults outside the formal educational system for improving their life styles and earning capacity.

The benefits of adult education in the spheres of health, hygiene and nutrition cannot be underestimated. The use of health science in adult education gives much scope for such benefits. Topics such as normal structure and function of the body, care of pregnant women, child care, health and human environment, nutrition and health, family planning, etc.,are included. (Sodhi, 1987) A.K.Sen defines nutrition education as a component of population education and emphasises the significant role the latter can play in population control(Sen, 1982).

The present study attempts to look into the various health benefits accrued to the past adult education learners in a village as against those in another village, who had little opportunity to attend adult education programme.

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II Objectives of the Study

The following were the objectives of the Study:

1) To compare the awareness, attitude and practice (AAP) of some MCH programmes by Adult Education Programme Learners and Non Adult Education Programme Learners.

2) To compare the AAP of Family Planning between the two study groups.

3) To compare the water and sanitation practices of the two study groups.

4) To compare the literacy and numeracy skills of the two study groups.

III Methodology

An epidemiological approach of case-control method was followed for the present study with a comparison between two groups: one with the input of adult education for one year (case/study group/ AEPL) and another having had little opportunity for undergoing the same(control group/NAEPL). Attempts were made to ascertain, through matching of AEPL with NAEPL, that respondents from both groups have the same sex composition, were of similar age groups and had been illiterates prior to starting adult education in the study area. The two areas are 4 K.M. away from each other having less chances of (contamination) interaction betweenthemselves.

Kavanur panchayat in North Arcot District, Tamil Nadu, had three AE centres between 1986 and 1987 with 90 learners, out of whom 43 had attended atleast 80% of the classes. Among those 43 learners, 34 were randomly selected for interview. The control group of 34 NAEPL were from Perumanguppam panchayat. The 34 NAEPL selected were those with the same age of the AEPLs and had been illiterates as per RUHSA's census in 1986. The total sample of 68 respondents were interviewed with the help of a interview schedule.

The following section deals with differences between the two groups in some of their socio-economic and demographic characteristics, AAP of (towards) health benefits, sanitation

practices and literacy and numeracy levels. Immunization, Antenatal Care (ANC), Family Planning (FP) and breast feeding are taken as indicators of their AAP as far as the health benefits are concerned. For sanitation practices, the frequency of taking bath and the sources of drinking water, and the place of garbage disposal were taken for analysis. In analysing illiteracy, the intra-group differences were differentiated by varying levels (il literates, semi-literates and literates) and their numeracy was ascertained by their varying abilities to count coins and rupees.

IV Results

IV.1 Socio-Economic and Demographic Characteristics of AEPL Vs NAEPL

Table 1 shows the differences between the two groups in some of the charac teristics mentioned above. Age and sex of the two groups were matched, so there was not much difference. The differences in other aspects are evident from Table -1.

It shows that the adult education centre studied had more unmarried females belonging to varying caste strata and working mainly as agricultural labourers. Whereas, though most of the (illiterate) non-adult education learners were females and agricultural labourers most of them were married, belonging to a single (Gounder) Caste* doing both houseold work as housewives and worki ng as agricultural labourers.

IV.2 AAP of Health Benefits

IV.2.1 Awareness

Table-2 shows the percentage of AEPL and NAEPL who were aware of some health programmes, as an initial step towards utilizing them.

Firstly most of the respondents knew that breast feeding is superior to bottle feeding and were aware of the permanent methods of family planning. The least awareness is noticed with respect to temporary methods of family planning. Secondly, relatively more AEPL were aware of i mmunization, ANC and the

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This has happened beacuse of this selection of control group from a single (main) village within the panchayat.

superiority of breast -feeding than NAEPL. Another aspect requiring serious attention is the difference in (all) the respondents' awareness between permanent and temporary methods of family planning, although the difference was not statistically, significant.

IV.2.2 Attitude

Like awareness, attitude is another prerequisite for practising (making use of) any benefits available to a targeted population. Table 3 shows the differences in the respondents' attitude of the two study groups with regard to various health programmes.

IV.2.3 Practice/Utilization

After being aware of a programme and having a positive attitude towards it,the next step is its practice or utilization, when the programme is available and accessible to the respondent. It is also possible that a respondent might have utilised a programme even without having a positive attitude towards it (eg. immunization, F.P. etc). This may happen due to the programme personnels' cajoling and pestering and/or due to other peer group's pressure. Table 4 shows the percentage of AEPL and NAEPL respondents who utilized/ practiced various programmes either himself/herself and/or for his/ her family members. The figures given in the table includes also those who advised F.P. to others especially when they can't practice it themselves or for their fami ly members. Breast feeding has been neglected due to the problem of numbers.

The table shows a disheartening picture for NAEPL as compared to AEPL. Among AEPL, 61.8 percent utilized immunization . The practice of ANC and FP was virtually nil among NAEPL, and among AEPL, the percentage of those who utilized ANC and FP services were 35.3 and 26.5 respectively. More than 97 percent of AEPL, especially the unmarried, advised others on FP, while the respective percentage is only 8.8 for NAEPL.

IV.2.4 Hygiene and Sanitation

The level of hygiene of the respondents and their sanitation conditions are explained in terms of their frequency of taking bath among AEPL and NAEPL, which shows that a higher proportion (44.1%) of AEPL took bath everyday than the NAEPL (20.6%).

Almost equal proportion of AEPL and NAEPL took bath on alternative days.

Table 6 shows the place of garbage disposal among the two groups. All the AEPL used pits for throwing wastes, while 58.8 percent of NAEPL used to throw on the fields, especially nearby their houses.

Table 7 shows the source of drinking water for the respondents. A high proportion of AEPL were using wells, while among NAEPL more households were using bore wells. More than 20 percent among AEPL were using taps whereas no one among NAEPL could use tap for drinking water. Use of unhygienic source of drinking water, like ponds, was not in vogue among the two groups studied.

IV.3 Literacy and Numeracy Among AEPL and NAEPL

Both the groups studied were illiterates prior to 1986, while one group, AEPL had the privilege of undergoing AEP for gaining literacy during 1986-1987. The present table, hence, shows the benefits of AEP in terms of literacy for AEPL. However, it is quite possible for the other group, NAEPL, to have improved their literacy position over one year. Also, though the NAEPL may not be literates as per the normal expectations, there might be individuals who have become partially literates.

Ninety-one percent among NAEPL were totally illiterates without being able to even sign their names, or to write/read one or two words in Tamil. Going by the conventional definition, all the NAEPL were illiterates. Among AEPL, 94.2 percent were illiterates as per the conventional definition. However, 32.4 per cent of AEPL learnt to write a few words and 5.9 percent became literates - able to read and write sentences with understanding. Since 8.8 percent among NAEPL were semi-literates, we may say, the benefits of adult education in terms of literacy is the number of semi-literates and literates it has additionally created. The benefit hence, amounts to 23.6 percent of semi-literates and 5.9 percent of literates.

V Conclusion

Though the preponderence of females over males in the AEP centres draws one's attention, the generally observed illiteracy among females justifies such imbalance to a certain extent. The presence of young unmarried females as learners provides

immense scope for long lasting effect of AEP on the learners and their families, especially with respect to various health benefits. Without being limited to a single caste group, AEP has served various caste groups in the panchayat studied. Many of the AEPL have learnt to write their names and read and/or write a few words in Tamil. The road is not too long for these semi-literates to become full fledged literates.

Most of AEPL were aware of immunization and ANC. Programmes like FP and ANC were not applicable to many of those AEPL since many were unmarried. But nearly all AEPL advised others on FP; They took bath every-day or atleast once in two days, had a separate place for dispos ing off the waste materials, and were able to count correctly the fruits of their hard labour, rupees and coins.

In conclusion, Adult Education Programme, if properly organized, can have many potential health and family welfare benefits in the target population.

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Table 1 :
Social and Demographic Characteristics of AEPL and NAEPL

	AEPL	NAEPL
No. of respondents	34	34
No. of Males	6(17.6)	3(8.8)
No. of females	28(82.4)	31(91.2)
Marital Status		
Married	12(35.3)	22(64.7)
Never married	19(55.9)	11(32.4)
Widowed	3(8.8)	1(2.9)
Age		
Less than 15	6(17.6)	5(14.7)
15 - 35	22(64.7)	23(67.6)
35 +	6(17.6)	6(17.6)
Caste		
Gounder	1(2.9)	34(100.0)*
Mandhiri	18(52.9)	-
Naicker	13(38.2)	-
Others	2(5.9)	-
Occupation		
Agri. cooli	22(64.7)	22(64.7)
Household work	9(26.5)	12(35.3)
Others	3(8.8)	-

n= 68

* This has happened because of this selection of control group from a single (main) village within a panchayat.

Table 2 :
Awareness of AEPL and NAEPL on various Health Programmes

Programme	AEPL n= 34	NAEPL n= 34	Difference in awareness
Immunization	76.5	35.3	41.2
ANC	94.1	29.4	64.7
FP Methods (Temporary)	2.9	8.8	5.9*
FP Methods (Permanent)	91.2	76.5	14.7*
Benefits of Breast Feeeding	100.0	85.3	14.7

* Not significant at 5% level

Table 3:
Percentage of AEPL and NAEPL having having positive attitude towards health programmes

Programme	AEPL	NAEPL	Difference
Immunization	97.1	76.5	20.6
ANC	97.1	Nil	97.1
F.P.	100.0	76.5	23.5
Breast Feeding	100.0	85.3	14.7

Table 4:
Percentage of AEPL and NAEPL who practiced/utilized various Health Programmes

	AEPL	NAEPL	Difference
Immunization	61.8	2.9	58.9
ANC	35.3	Nil	35.3
F.P.	26.5	Nil	26.5
Advised F.P	97.1	8.8	88.3

Table 5:
Frequency of taking bath among AEPL and NAEPL(percentage)

Frequency	AEPL	NAEPL
Everyday	44.0	20.6
Alternate days	52.9	52.9
Twice a week	2.9	26.5
Total	100	100

Table 6:
Place for Garbage Disposal among AEPL and NAEPL

Place	AEPL	NAEPL
Wastage Pits	100	41.2
Field	-	58.8
Total	100	100

Table 7:
Source of drinking water among AEPL and NAEPL

Source	AEPL	NAEPL
Well	55.9	44.1
Tap	20.6	-
Bore-well	2.9	55.9
Well/Tap/Borewell	20.5	-
Total	100	100

Table - 8

Percentage of AEPL and NAEPL under varying Literacy and Numeracy levels

Level of Literacy	AEPL	NAEPL
1. Illiterates	61.8	91.2
Semi Literates	32.4	8.8
Literates	5.9	-
2. Numeracy		
Ability to add rupees	82.4	79.4
Ability to add coins	82.4	64.7

18. MASTURBATION - NEED FOR TACIT SOCIETAL ACCEPTANCE AND LEGITIMIZATION

*M.S.Rao**

"Let him, that hath never sinned, cast the first stone at her"-her Jesus Christ, while protecting from mob justice, a woman accused of the crime of adultery.

I Introduction

As society has become more and more permissive in values, traditions and taboos towards sexual concerns of its members, a sea change has occured towards liberalisation in this respect over the ages, though not uniformly in the different regions of the world. Examples are to be found in the altered attitudes or even controversies over ritual male circumcision(or the corresponding clitoris amputation or infabulation in the female child), family planning and birth control methods, celibacy required of priesthood or temple dancers, and promiscuous heterosexual or homosexual activity. For the last named, while recognising the inherent risk of sexually transmitted disease including AIDS, it is also recognized that one cannot effectively curb some compulsive individuals, and instead, the use of a condom as protection against such diseases is advocated by the medical profession as the next best alternative! Trying to alter or reinterpret religion-ordained dogmas on sexual concerns is difficult, even when supported by scientific evidence, and even though the information can be widely disseminated to the public by the print or electronic communication media.

Masturbation is one such sexual practice which needs to be seen differently today. It is defined as simulated sexual act gratification from the stimulation of the male or female sexual organs obtained repeatedly by an individual of either sex, taking aid of imaginary sexual partners/ situations or rousing one's sexual urge by the use of erotic literature, blue films, etc.

In the ancient texts of the majority of the world religions, restraint towards sexual activity till marriage has been emphasised. The sociological reasons behind such a taboo is quite understandable. Although one is biologically ready for procreation at puberty itself

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(12-14 years of age), one is not quite as prepared for the responsibilities of rearing children so early in life on account of educational and psychological immaturity. The age of marriage for both sexes is being raised in the interest of MCH and population control. This has further increased the gap between first sexual awareness and socio-legal sanction for sexual intercourse. This insecurity of an impressiobale,immature mind placed within a body bursting and ready for sexual performance, is compounded further by the implications of guilt and sinful conduct inculcated towards masturbatory activity by religion (eg. Christianity); suggestions of future phsical weakness, lack of mental concentration, and lack of future potency or fertility, etc. (Eg. Sexual continence advocated in Hindu religion during the "brahmacharya" or bachelorhood stage of life,followed by permission for sexual intercourse during the "grihasthashrama" married life status only,in the Vedic scriptures.)

Biologically, there is no proof of any subse quent loss of male physical, mental or sexual prowess and fertility status (i.e. semen quality) in an individual practising masturbation for relief of sexual urges. In fact, this is to be considered a safer outlet than trying to seek relief by visiting houses of ill-repute and exposing oneself to the risks of dangerous sexually transmitted diseases. Masturbation should therefore be looked upon as a "release phenomenon" necessary for present day youth to obtain sexual gratification before they get married (or even as a family planning measure after marriage!). It is interesting to know that primates (monkey family), closeted in zoo cages with deprivation of mates or under arrangements of poor privacy, begin resorting to masturbatory practices.

In my pracitice as a urologist(where I deal with problems related to the male sexual organs besides urinary tract diseases), quite often I am confronted with sexual performance problems related to the above misconceptions in the youth. One such misconception relates to fear of loss of sexual potency and inability to have satisfactory intercourse with his married partner, despite the fact that he was able to perform masturbation and even give a semen sample for testing! On close questioning, a sizable majority of these young men admit to feelings of guilt towards past masturbatory practices or an unguarded moment where they had extramarital sexual relations. Their concern for not passing on any sexually transmitted disease to their trusting, unwary married partners, is the usual psychological reason for the hesitation towards performing

the sexual act properly after marriage. Reassurance and exclusion of actual disease by the doctor sets right the problem, but the time taken to achieve results would vary with the degree of influence of the misconceptions on the young man's mind.

Another situation in unmarried young men is the complaint of "wet dreams" or "nightfalls"occuring during sleep hours, of which evidence gets known in the morning when the clothes or bed is seen to be stained with semen. This involuntary spillage of semen is very upsetting to those living on a community basis either at home or in hostels, boarding houses, etc. Interrogation tactfully re veals an attempt of sizable numbers of such people trying to practice sexual continence by deliberately damming their sexual urges and suppressing these desires for fear of imaginary after-effects on their general and sexual health. We explain to these individuals that Nature is trying to keep the supply of seed and secretion constantly replenished, for which periodic emptying away of the old stock is essential, which is what deliberate masturbation (once or twice weekly) achieves for them. Their awkward symptom ceases as a consequence and they begin to feel they are in control of their sexual aberration. Otherwise Nature chooses an unguarded moment to achieve the same purpose! The biological truth is that, the longer the semen (sperm) are conserved (more than three months), the older (senescent) and less capable the sperms are to fertilize the fe male egg(ovum) for the production of a baby. This is quite contrary to the advantages of "brahmacharya" advocated in the religious literature.

Society is even more intolerant towards females seeking relief by their own methods of masturbation practices. With their age for marriage having been raised recently, the time gap between sexual readiness, and opportunity for postmarital regular intercourse, has increased. The inculcation of improper ideas of guilt, sin or imaginary health hazards would bring in its wake, problems already evident in the male in future. They would require the same sympathy understanding, tact and adoption of a matter of fact attitude to their relief act, as for the male.

The ultimate societal attitude towards masturbation should become similar to what it allows for other acts of privacy considered to be necessary, such as urination and bowel evacuation.

19. YOUNG LADIES HEALTH - A CHALLENGE FOR SOCIETY

*Archana Parulkar**

I Introduction

The year 1990 was designated to the International Year of Female Child. It is further extended as the Decade of the Female Child. This is to focus professional attention on the concept of survival and development of female child.

It will not be sufficient merely to achieve survival and development of female child. The physical mental and emotional health of young female adolescents and ladies is equally important.

Presently, both in the family and for the health services, the young lady as a female, has low status, and being an adolescent, low priority as far as her health is concerned. Many cultural restrictions are imposed upon her. She is under the stress of rapid growth and sexual maturation. Yet there is no health programme targetted for the female adolescent. Parents are not alert about the health of their daughters. The school health services, being at a rudimentary stage,these girls are not covered by health services. And the society has not yet realised that health of these young ladies can be a health need/felt need of the community; even a megapolis, like Bombay, shows a pathetic state of health of young ladies.

This study, based on observations of girls of two schools of Bombay, illustrates how the health of young ladies is a challenge for health services and also for the society. Both schools were reputed and famous for their academic standards.

II Results

The results of the study are indicated in Tables 1 - 8

II.1 Health Status of the School Girls before Intervention

Table 2 reveals that the anemia was the predominent mordibity.

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None of these girls were severely undernourished. When inquired about diet pattern, there was no imbalance but at times it was a faulty diet. A few girls were conscious about their weight and were dieting without medical advice. Very few were aware about additional required nutrients e.g. iron, at this juncture of life.

Anaemia is simple to detect and treat. It is usually seen that most of the people are unaware about the serious implications of anaemia. It can impair the general health and, reduce the performance. It also can precipitate the complications during reproductive phase, adding to maternal mortality.

As such, menarche is a crucial stage in the life of every female. The young ladies undergo great physiological, mental and social changes. These stresses are not to be discussed openly. Majority of these girls were not mentally ready for menarche. Anaemia adds to these stresses. With a little effort, in time one can improve the situation.

Table-3 indicates that many girls were anaemic but majority were borderline, vulnerable to become frankly anaemic. More details were elicited to pinpo int the etiology of the condition. Two common causes of aneamia at this age were found to be menorrhagia and worm infestation.

Table 4 reveals that presence of anaemia must be investigated and promptly treated so that these girls will not become high risk later on. All anaemia girls from both the schools had one or more complaints. These complaints might appear non specific and vague. But they were reported to be definetly disturbing the daily life and performance. Some medications like analgesics and tranquil izers were tried by these girls but obviously there was no relief.

Any of these complaints can be mistaken as malingering or excuse for shirking the work. This can cause family and social conflicts for them. In this group, few had only one complaint but majority had multiple complaints making their family life miserable.

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* Anaemia as per W.H.O standards

1I.2 Health Interventions Attempted

All these girls were advised specific treatment with broad sepctrum antihelminthics, heamatinics and nutrition education. It is well known that dietary in take of iron has limitations for its absorption in the intestine and utilization by body. Hence during frank anaemic state, medicinal iron only can help to improve the haemoglobin level.

To this, the compliance of parents was shockingly disappointing.

Then the principals and teachers were motivated to influence the girls and their parents to take the treatment advised.

III Results of Health Interventions

The picture after treatment was really rosy as shown in Table 8. The girls themselves could feel the change. They admitted that confidence, enthusiasm and personality change gained, were going to make their life more fruitful.

IV Conclusion

In conclusion one can bring out few important facts about health of young ladies who have just crossed menarche.

i) Anaemia does exist among adolescent girls and can become chronic if not treated

ii) The ill health caused by anaemia is hampering the progress and development of these girls. Shockingly, parents are not giving importance to the referral notes given by school regarding the health of their wards.

iii) Early diagnosis and prompt treatment of anemia and other conditions can set things right.

V Recommendations

1) As said by C.C.Coltan- *The excesses of health of youth are drafts upon our old age, payable with interest about thirty years after date* - should be kept in mind while planning school health services.

2) Parents must really introspect and confirm that they are really looking after the health of their wards, especially those crossing puberty .

3) Society also must realise the importance of health of young ladies who are potential mothers.

4) The female child who survives the early fight with the health problems should not be allowed to die or ail while giving birth to her child.

5) All Medical and Health practitioners should ask one question to all school children and young ladies whether there is any referral note from their school.

6) Adolescence and youth is a receptive and impressionable period of life, which can be used for the dissemination of health knowledge, the development of health, life-style and the establishment of understanding and support of community health measures. This has been reiterated in 1985 i.e. International Year of Youth.

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Tabel 1
Health Status of the School Girls before Intervention
& Characteristics of the Study Groups

	School B	School M
School	at Dadar	at Bandra
	Total 3000 students	Total 4500 students
	School health services available	School Health Services available
	+ ve attitude towards health of students	+ ve attitude towards health of students.
Students (young ladies)	Std 7th to 10th Menarchae in (534)	Std 7th to 10th Menarchae in (778)
	Bet 11 to 16 years	bet 11 to 16 years
	Average age at Menarchae 12.5 years	Average age at Menarchae 12.00 years
	Higher Middle income group	Middle income group
	Parents literacy 95%	Parents literacy 90%
	Compliance by parents-poor	Compliance by parents - poor

Table 2
Distribution of School Girls by Morbidity

Problems	School B	School M
Anaemia	26.1%	30.0%
Other Nutritional Disorders	10%	11.0%
Dental	28.0%	32.0%
Opthalmic	19.1%	22.0%%
Other	3.7%	2.9%
No obvious problems.	4.3%	1.8%

Table 3
Distribution of School Girls by Severity of Anaemia*
Anaemia as per W.H.O standards

	Anaemic	Borderline	Normal
School B (534)	166(31%)	246(46%)	122(23%)
School M (778)	311 (40%)	405 (52%)	63 (8%)

Table 4
Distribution of School Girls by Severity and cause of anaemia

School	Anaemic		Borderline		Normal	
	Stool + ve	Meno-rrhagia	stool + ve	Meno-rrhagia	stool + ve	Meno-rrhagia
School B	109 65.6%	112 67.4%	128 52.0%	147 97.7%	14 11.4%	Nil 0%
School M	218 70	214 68.8%	296 73.0%	251 61.9%	09 14.5%	Nil 0%

Table 5
Distribution of Anaemic School Girls by Complaints

Complaints Reported	School B (166 girls)	School M (311 girls)
Headache, dizziness	60 (36%)	119 (38.3%
Breathless after routine work/exercise	38 (23.1%)	83 (26.7%)
Easy fatigne, low mood	29 (17.6%)	67 (21.4%)
Anorexia/reduced appetite	26 (13.6%)	40 (12.9%)
Insomnia, Giddiness	18 (9.5%)	35 (11.2%)

Table 6
Distribution of Anemic Girls by frequency of complaints

Complaints	School B	School M
Single	25 (15%)	35 (11.2%)
Multiple	123 (74.1%)	246 (79.1%)
Multiple with obvious pallor	18 (10.8%)	30 (9.6%)
Total Anaemic Girls	166 100%	311 100%

Table 7
Distribution of School Girls by Compliance of Parents

	School B	School M
No compliance	411 (76.9%)	597 (76.7%)
Partial compliance	95 (17.8%)	147 (18.9%)
Full compliance	28 (5.3%)	34 (4.4%)
Total	534 (100%)	778 (100%)

Table 8
Distribution of Response of Parents to Efforts of Doctors, Teachers and Principals

	School B Cumulative	School M Cumulative
Repeat advice by doctors	124	287
Motivation by teachers	403	689
Intervention by Principal	491	700
Hard core	43	78

Table 9

Status of School Girls before and after intervention
(distribution of iron) by severity of anaemia

School B	Anaemic	Borderline	Normal
Initial	166 (31%)	246 (46%)	122 (23%)
after one month	27 (5%)	117 (22%)	390 (73%)
after 6 months	5 (1%)	46 (9%)	483 (90%)
School M			
Initial	311 (40%)	405 (52%)	62 (8%)
after one month	124 (16%)	233 (30%)	421 (54%)
after 6 months	39 (5%)	76 (10%)	663 (85%)

$B - X_2 = 503 \quad P < 0.001$

$M - X^2 = 934 \quad P < 0.001$

20. ADOLESCENTS' PERCEPTIONS OF HEALTH

*D.S.Sheriff**

I Introduction

The World Health Organization has defined health as " physical, mental, emotional and social well being, not merely the absence of disease or infirmity"(1).

Health problems, concerns and worries of youth are conceptualized differently by young people in comparison with the views of adult health professionals and planners. Health problems of youth tend to have a strong psychosocial behavioural component. Depression, getting along with parents and sibs, nervousness, making friends, acne, obesity and development into an adult - are important issues that require attention. The WHO designed four major but overlapping areas of concern of adolescents - biological/medical issues; sexually related problems; risk-taking behaviour; and, psychiatric and emotional problems.

From a biological perspective, statistics show that adolescence is a reltively healthy time of life. Mortality and morbidity rates are low in comparison with other age groups; passive and active immunity have usually been acquired during childhood and the vascular and degenerative disorders of middle and old age are not evident. Many of the medical disorders of adolescence are not life threatening. But, " the conseuquences for the individual adolescent and his family, as well as the adolescent group as a whole, represent a gross reduction in terms of the achievement of optimal life experiences and opportunities"(3). It is important therefore that they be taken seriously.

II The Normal Events of Puberty

Puberty (pubertus-Latin- the age of manhood) is defined as that time when one becomes able to beget or conceive children. Pubescence (pubescere - to grow hair) refers to the period during which physical changes are occuring. In recent times there has been a great change in the physical events characterizing adolescence. The age of onset of sexual maturation has been

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decreasing, growth and physical development are proceeding at an accelerated pace and there has been a trend towards greater ultimate adult size. Many aspects of this acceleration remain obscure, although such factors as better nutrition, heteros is, improved social conditions and urbanization are probably relevant.

"Physically, the adolescent is like a house on moving day-- a temporary mess", (4). There is dramatic growth of the skeleton, muscles and viscera, sex-specific changes in body shape, change in body composition, changes in the system and secondary characters. The visible events of growth probably follow a normal sequence, although there is greater variability in the time of onset, the velocity of change and the age of completion of these events. The average duration of puberty is three years but can vary from 2 to 5 1/2 years in boys and 18 months to five years in girls.

The Tanner staging system of pubertal development is based on breast, genital and pubic hair - changes with stage I being the prepubertal and stage five is the adult developmental changes. "By recording the maturity ratings of adolescent patients, it is feasible to follow the growth of subjects, estimate the velocity of change and perhaps detect early abnormalities(5). Sex maturity ratings (S.M.R) indicate the biological state of development which correlate well with other events of puberty. Menarche most often occurs in girls quite late in puberty and is generally preceded by atleast two years of breast development. Breast size is often unequal initially, with greater symmetry occurring with time. Girls are particularly sensitive about this.

Boys may achieve their first ejaculation (semenarche) mostly during masturbation or sleep, about a year after the beginning of penile growth. Facial hair may appear after axillary hair, both being relatively late pubertal events. Voice changes related to growth of vocal cords takes one to three years to be complete. Gynaecomastia of mild degree may occur in 60 to 70% boys", and gradually subsides in six to eighteen months time. Infrequently, it is more marked and persistent and where psychological disturbances is great, and surgical excision may be required.

Overall, the experience of puberty is to have a changing body which gives a feeling of being out of control. There may be feelings of helplessness which do not reduce until 12 months after the growth spurt has ended. A heightened awareness of bodily

changes and feelings of persecution are normal and common at this time. For these reasons, real or imagined problems to do with young person's development or health can cause anxiety or distress.

III Common Problems Experienced During Puberty and Adolescence

III.1 Sexual Problems

While trying to achieve optimal growth and sexual development, adolescents are particularly vulnerable to adverse personal and environmental influences such as nutrition, infections, social and economic privations. Adolescents out of step with their peers may face a psychological crisis whose impact may prove grave and great at times.

III.2 Problems of Growth and Sexual Development

Delayed puberty is defined as absence of pubertal development by 13 1/2 years of age in girls and 14 years in boys or failure of developmental progress over a two year period.

The most common cause is consititutional delay of puberty with or without short stature, although other causes such as chronic disease or endocrine dysfunction must be excluded.

Short stature in boys, greater tallness (180 cm) in females provide cause for concern in our society, most cases are genetic in nature with one or both parents being tall or short. Whether short or tall, accurate assessment is important, counselling and objective reassurance essential and rarely hormonal intervention may be justified.

III.3 Menstrual Disorders

Menstrual disorders are common in adolescents during the period when endocrine maturation is occurring. The commonest abnormality is secondary amenorrhoea, whilst primary amenorrhoea is rare. Menarche is delayed by undernutrition and strenuous exercise as observed in many women atheletes. Oligomenorrhoea (infrequent menses) is common during the first few years after menarche and does not require intervention (e.g. hormonal regulation) unless it is persistent and severe. However, "

those girls with a history of cycles of over two months for more than two years are likely to have persistent menstrual problems in later life with infertility due to defective ovulation. Repeated heavy menstrual bleeding is rare and is associated with a poor reproductive prognosis(5). Dysmenorrhoea is very common in adolescents and can occasionally be severe and disabling. Detailed investigations is not usually indicated; reassurance and simple methods are generally sufficient; otherwise a prostaglandin inhibitor (e.g. ponstan ii tds) should be prescribed.

III.4 Nutritional Problems

Adolsecent nutrition is a subject of considerable concern and myths abound. Normally, as a results of increasing rate of growth and physical activities, adolescents have relatively high nutritional requirements. In par ticular, the energy demands of puberty are high and the timing of the growth spurt is of major relevance.

The major concern of nutritional problems is obesity in some adolescents. Inappropriate eating habits, consititutional obesity, underlying psychosocial problems, and rarely, an endocrine cause or syndrome are some of the factors implicated in obesity. "Psychodynamic issues with the individual and the family are particularly important in understanding and dealing with the multifaceted challenge"(6) presented by obese adolescents. A diet alone does not provide a cure, and in the case of constitutional obesity, it is contra-indicated(7).

The risks for cardiovascular disease and other problems in later life rai se special concern and dictate the need for further research into aetiology and effective intervention.

III.6 Skin Problems

Acne is almost universal in adolescence with no young person escaping a few comedons and pustules, and majority having manifest disease. It is a multi factorial problem as a result of adult levels of sebum output,adult levels of circulating androgens, the corynbacterium acnes,the liberation of free fatty acids in the skin, and heredity. In girls it increases premenstrually.

The impact of acne upon young people is underestimated. "Time spent in general discussion with the patient so that his

particular problems, concerns and fears can be considered, is well spent"(8). Physicians should explain what acne is and how it develops, emphasize that it responds slowly to treatment. Drying agents and antibiotics remain the mainstay of therapy, whilst diet is considered to be less important. Vaginal moniliasis is a general problem for girls. Atopic eczema, tinea cruris and scabies are other infrequent skin problems of adolescents.

III.7 Orthopaedic Conditions

A number of arthopaedic conditions occur common in adolescents such as idiopathic scoliosis in girls, whereas Osgood-Schlatter disease and slipped upper femoral epiphysis are more common in boys. Operative measures or other interventions may be necessary to accomplish bony fusion in such cases of curve defects.

III.8 Chronic and Disabling Conditions

The prevalence of chronic and disabiling conditions in adolescence represent a significant problem affecting quite a sizeable populatioin. These may be genetic or acquired through accidents. Some of the chronic and disabling conditions are listed in Table 1. These chronic illnesses may result in:

- Enforced dependency and over protectiveness which may hinder efforts to separate the individual from the family.

- Acceptance of one's own body deformity or imperfection may play a greater role in establishing the psychosocial identity.

- Future economic independence may be hampered by interference with educational or vocational goals by illness.

- Isolation from one's peer group and the resulting loss of self-esteem (8) will hold back the development of a realistic, stable, positive adult self-iden tity.

In early adolescence, disruption of body image and isolation from peers are likely to be a major concern, whereas middle adolsecence,the impact of enforced dependency and decreased acceptance by peers can take a high toll. For ill or injured youth in late adolescence, impaired relationships with special friends,

concern about future commitments and family, and effects upon educational and vocational goals are the important considerations.

III.9 Behavioural Responses to Illness

Normal adolescent behaviour is to a great extent experimental in nature and understanding its meaning in ordinary circumstances is challenging enough. It is quite unrealistic to expect a normal behavioural response from an ill or disabled teenager. It is but natural for the youngster to accept the reality of the situation with some sense of personal devaluation. There is an "inevitable interplay between the illness on the one hand and the intense body image concerns that stem from preoccupation with pubertal changes on the other. These factors render the adolescent singularly vulnerable to the psychological complications of organic disease. The responses shown by a teenager to an illness is summarised by the views of Daniel Jnr.: DENIAL is a common adolescent reaction to illness. Many adolescents intellectualize to cope with illness and try to separate fact from emotion. Usually that is short lived and emotions do surface, bringing about another coping mechanism such as rebellion or noncompliance. Occassionally patients find it easier to regress to a younger emotio nal period of life than to cope with reality. Some adolescents believe that they are personally to blame for their illness or disability or that God is punishing them for their sins (ideas which may be fostered or reinforced by illadvised, well - meaning adults). In such situations, guilt and self anger become intolerable, and as frustration rises there is great hostility which is projected out to nurses, doctors and paramedical personnel. Severe depression, withdrawal or self isolation also occur. Other maladaptive types of behaviour are panic and acting out. The latter is a symbolic behaviour best understood as an alternative to facing strong feelings associated with a conflict. It may also elicit care from important persons, provide a means for gaining attention and test the limits of the social setting.

IV The Dying Adolescent

The issues confronting the dying adolescent are particularly poignant. By 8 to 10 years of age most children do understand the meaning of death. The dying teenager resents dishonesty, will always be aware of the seriousness of the situation and if a climate of communication is maintained, will generally learn what he is ready to learn. The conspiracy of silence must be avoided. There

is also the important question of the adolescent's rights versus those of parents.

General principles of adolescent care must be the basis of management of the adolescent who is dying(10). They must be given every opportunity and encouragement to take part in decision making so that a feeling of participation and self-control is maintained. The person with whom the adolescent is best able to communicate must be made available whenever is needed and peer relationships must be encouraged both at the hospital and at home.

V Risk Factors for Future Health

Adolescence is a vital time to intervene in a preventive manner. The early onset of obesity, hyperlipidaemia, hypertension and diabetes mellitus are significant in this sense.

"Adolescents appear to be either killing themselves or choosing a lifestyle that will determine their mode of dying later on"(11). This concept of continuum thus highlights the fact that adolescence provides a crucial access point for improved adult health an issue of great importance to society. Thus for a better health care to adolescents, one must understand the contrasts in health care delivery between the conventional and Innovative poles which is summarized in the Summary.

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Table 1
Selected Chronic and Disabling Conditions in Adolescents

1. Chronic disease	2. Physical Handicaps
- epilepsy	- cerebral palsy/paresis
- Asthma/cystic fibrosis	- Visual, hearing, speec h defects
- Diabetes	- Spina bifida other genetic disorders
- Juvenile Rheumatoid arthritis	- Facial deformity
- Cardiovascular disorders	- Traumatic lesions
- Inflammatory bowel disease	
- Malignancy	3. Intellectual handicaps
	- Learning disorders
	- mental retardation

Summary

Table - 2

Dimensions	Convention Pole	Innovative Pole
1. Ideology	Conservative: Pathology or Change - oriented	Radical: growth - oriented
2. Techniques	Psychotherapy counselling	Participation Counselling
3. Staff	Highly skilled professional	Non - Professional
4. Staff/patient	Roles well-defined	Sometimes vague
5. Intake	Defined groups	Self-selecting
6. Location	Therapist's territory	Client's territory
7. Access	Formalized-fixed hours	Informal-flexible
8. Confidentiality	May include parents	Anonymity

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21. AN EXPLORATION INTO THE CHOICE OF WORK AND ROLE BURDEN AMONG CHILD LABOUR

G.R.Sundaravadivu and U.R.Kaliappan**

I Introduction

Child labour is not new to India. Only the ideas regarding child labour have changed tremendously. In traditional social systems work-participation of children was a part and parcel of the socialization process. The motive was to transmit the hereditary skills of livelihood of the family to succeeding genera tions. Even in the age -old Gurukula setup, there was no strict division between household duties and their studies.

Initially, children were working in agriculture sectors which is mostly family oriented. Even at that time, their work went along with their education and recreation and this continued till the existence of putting-out system. Today, along with the changing economic structure, and particularly in the light of the fast pace of development, children are drawn much more into this special world of " Child Labour Force'. The Industrial Revolution, by ushering in the Factory system, completely changed the scene. The early period of the Industrial Revolution, although it triggered development in every sphere, failed to anticipate its effects on children. Factories brought children under one roof as workers and producers for the Nation. They were forced to work outside the house along with shouldering household responsibilities. Children were appointed as apprentices and labourers in artisanal workshops and Small Scale Service Sectors. Therefrom, the child started to play a crucial role in the Family, Community, Economy and Nation.

Today, the process of Industrialization has brought in a major change in family system and this resulted in giving an economic value for a child's work. In due course, family factors such as poverty and unemployment, and industrial considerations such cheapness of child labour, resulted in children forming a full fledged substantial industrial labour force. Thereafter, economic value was attached to child labour. But neither families nor the industrialists

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made an attempt to check on the working conditions of children, their tedious journey to the work place, or their repetitive, monotonous and more risky job. Thus the childhood of the nation's children is snatched away, as also education and recreation.

This problem has been largely tackled in developed countries with legislation and economic prosperity. But it continues unabated in developing countries. ILO Statistics(1988) estimated child labour under fifteen years as 55 million for the World as a whole. A study of the Economic and Social Council of United States figures it out as 145 million. These organizations also brought to light that child labour is mostly found in underdeveloped countries. India has the dubious distinction of having the largest child labour force in the world (about 45 million).

Though employment of children is visible in every sector it is comparatively higher in the primary sector. In spite of restricting child labour, many industries like the glass industry of Ferozabad, brass work of Moradabad, pottery industry of Khurja, gem cutting of Jaipur, the lock industry of Aligarh and fireworks of Sivakashi are employing them. Adding to this, hosiery units of Tiruppur have also become a pocket of child labour now.

II Background of Child Labour in Tiruppur

Tiruppur with its wide market for hosiery products, employs a large number of child labourers. In the absence of children's contribution, every hosiery unit is likely to be handicapped as children constitute one-third of the total labour force. They are designated as "helpers" to the adult workers. Under this designation they engage in the most important tasks like bundling, tri mming and labelling. When compared to their fellow workers anywhere, they draw a handsome income. Their income ranges from Rs.7-10 per working day of eight hours work, an additional Rs.2.75 for every extra hour of overtime work. The regular working hours are from 8.00 A.M. to 5.00 P.M. with regular rests and intervals. As most of the units flourish with export orders they normally have one and a half shifts(8.00 A.M. to 9.00 P.M). When urgent orders are placed with these units they work even beyond midnight or even stay until the next day to meet their commitments. Thus, their approximate monthly income ranges between Rs.180/- to Rs.370/- for regular work, and reaches Rs.600/- when overtime wages are included.

The availability of this job with a high scope and attractive wages distracts the schoolgoing children of the farming and working class families in and around Tiruppur.

This paper examines the process and factors influencing school dropout and getting into the labour force among boys and girls working in these hosiery uni ts. Seventy five boys and an equal number of girls working in seventy five hos iery units were studied for the purpose. The second focus of this paper is the unpaid household tasks performed by these male and female children.

III Pattern of School Dropout

Secondary importance is given for girls' education. This appears even at the stage of enrolment. One seventh of girls are not enrolled at all as against almost complete enrollment of boys. Another significant difference in schooling is that every fourth girl discontinued her studies after finishing fourth standard, but before completing primary education while such boys account for one half of the proportion. A larger proportion of boys complete their primary education. Thirty seven percent of boys and thirty three percent of girls got enrolled for secondary education and dropped after eighth standard. There is no difference by sex at this level.

Poverty is the principal factor for dropout of both the sexes (48.6 percent of males and 39.1 percent of females) followed by attractive income and aversion to studies as well as problems in studies.

IV Factors Influencing the Decision to Work

Among the dropouts, 13.3 percent of males and 14.7 percent of females entered work during summer vacation of the school intending to continue their studies. However the attractive income tempted them to continue work and discontinue education. While push factors are predominant in other fields, it is the pull factor of an income perceived as fabulous which brings in children into the work. Half of the boys and girls repent now for having dropped out of school, though they are now in the labour force. They long for an opportunity to continue their studies.

Three fourths of the respondents of both the sexes do not want their younger siblings to become a child labourer. They attribute high value to education now, and this is the crucial factor which makes them discourage their siblings from becoming child

labourers. More than fourty percent of the respondents felt deprived without education. A greater proportion perceives education as a step ping stone to gain status in society.

V Pattern of Daily Life of the Child Labourers

The time schedule of these children highlights their busy working hours and work burden for more than eighteen hours. Though all children are early birds, girls get up earlier than boys. All but six females (90%) reported getting up before 6.00 A.M. in the morning while only 65% of the males wake up before 6.00.A.M. More than one third of the females, leave for the job at or before seven in the morning, though majority (around sixty five percent) of children leave for work between seven and eight A.M. Over three fourths of the respondents return home by 9.30 P.M. while almost one fifth of both the sexes reach home after 9.30 P.M. Many go to bed before ten, while one fourth of the females and one fifth of the males sleep after ten. Half of the females compared to one fourth of boys get less than eight hours of sleep.

VI Additional Household Responsibilities of Child Labourers

Between the sexes, females are more burdened with unpaid domestic work alongside factory employment. Parents demand their children's assistance in the morning hours. The tasks like cleaning, washing, fetching water and vegetable cutting are mostly shouldered by daughters while marketing is done by sons.

VI.1 Sex Differentials in Household Responsibilities

Statistical analysis showed that the variables of parity, number of childr en in the family, number of employed children in the family, and mother's employment status, had no bearing on childrens' household responsibilities. In case of male respondents, there was no significant association between family size and household responsibilities. Whereas there is a positive association with regard to females. Involvement of female children in household chores is rela tively greater in larger households. Besides getting up early and going to bed a little later than boys, even the available leisure time of girls was not at their disposal. When they have more free time, their participation in household chores also increases. In case of boys commuting to work, their participation in household responsibilities was less, whereas the commuting girls have to

complete the tasks entrusted to them,before leaving for work. Hence it is evident that female children are overburdened.

VI.2 Sex Differentials in Leisure Activities

As overtime work is common, Sunday is the only day for children's leisu re. A marked difference between the sexes is seen in leisure time activities. For females, there is no difference between their daily routine and weekend activities. Males displayed a willing participation in household tasks only at the weekend. After completing household tasks, watching television and chatting are the major recreational activities for girls, while boys enjoy the freedom of going for movies or roaming with friends.

At the work place, there is no discrimination between sexes. Though they earn equally and share the burden of parents, girls are treated differently at home. They are overburdened with household chores. Many restrictions are imposed on them. Though friendship is encouraged by parents in both the cases, outings by girls with friends is not approved or encouraged. In giving money for personal expenses also, discrimination is noticed. Nearly one third of female respondents do not get pocket money while it is only one tenth in the case of males. Among those who are getting pocket money, the amount ranges between Rs.6-15 for girls, and Rs.30/- in case of boys. Many girls are questioned by their parents as to how they spend the money ; less number of boys are answerable.

In general, irrespective of the sex, the labour of young children is exploited in different ways by both family and the larger economic order, and further, the condition of the weaker sex is worse compared to male. Young girls put in longer hours of work at home, while working outside for the same period as males do. The sex-role stereotypism in society makes the parents show this level of differential attitude towards female children. The girls are socialized in different ways to prepare them for a submissive role tomorrow. The seed for it is sowed here. Parents who are expected to provide food, clothing and shelter, instead, expect their childrens' assistance for family's survival irrespective of sex. In such cases it would be expected that they would also treat the children equally irrespective of sex and endow them with equal opportuni ties in every sphere.

VII Summary

Employment of children in hosiery industry is common knowledge. Some of the problems associated with child labour emanate from the young age on the one hand and from the perspective of human values as well as human resources development. This paper examines the process and factors involved in school dropout and joining the labour force, among boys and girls working in the hosiery industries of Tiruppur. Seventy five boys and equal number of girls working in 75 hosiery units were studied for the purpose. Most of these children dropout of school after having enjoyed the experience of income from work during vacatio ns. The attraction of income is the most common motive behind this shift, foll owed by poor economic conditions of their family.

The second focus of this paper is the non-work household tasks performed by these children. Most girls have to shoulder domestic chores on a regular basis, while boys tend to involve marginally in the household routine at the weekends. This burden is reflected in the time budget for both sexes and in the highly limited leisure time activities of girls as well.

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Table 1
Respondents by their level of schooling

Completed years of schooling	Male		Female	
	No.	%	No.	%
0	1	1.3	11	14.7
1	1	1.3	1	1.3
2	6	8.0	6	8.0
3	6	8.0	6	8.0
4	9	12.0	19	25.3
5	24	32.0	7	9.3
6	18	24.0	16	21.3
7	4	5.4	4	5.4
8	6	8.0	4	5.4
9	-	-	1	1.3
Total	5.01		4.8	

Table 2
Reasons for respondents drop-out

Reasons	Male		Female	
	No.	%	No.	%
Poverty	36	48.6	25	39.1
Attraction of income	30	27.0	15	23.4
Problems in studies	14	19.0	16	25.0
Problems in family	4	5.4	8	12.5

Table 3
Reasons for not encouraging younger siblings to join the hoisery labour force

Reasons	Primary				Secondary				Tertiary			
	Male		Female		Male		Female		Male		Female	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Can get a regular employment	4	7.2	6	11.1	5	9.1	9	16.7	4	7.2	5	9.1
Can get better income	3	5.5	3	5.6	1	1.9	2	3.7	12	21.8	4	7.4
This is not a prestigious job	3	5.5	1	1.9	7	12.7	6	11.1	5	9.1	4	7.4
Can get a job with shorter working day	8	14.5	6	11.1	12	21.8	10	18.5	10	18.2	2	3.7
Education gives recognition in the society	12	21.8	15	27.8	2	3.69	7	12.9	10	18.2	5	9.1
I am deprived. Let my siblings benefit	25	45.5	23	42.5	12	21.8	9	16.7	6	10.9	2	3.7

Table 4
Timings of the Respondents

Time	Male		Female	
	No.	%	No.	%
Getting Up				
4.30 - 5	9	12.0	17	22.7
5 - 6	40	53.3	52	69.3
6 - 7	26	34.7	6	8.0
Starting for work				
5.45 - 7	8	10.8	27	36.0
7 - 7.30	37	50.0	21	28.0
7.30 - 8	29	39.2	27	36.0
Returning Home				
5.30 - 7.30	5	6.7	13	17.3
9 - 9.30	55	74.4	46	61.4
9.30 and above	14	18.4	16	21.3
Goint to bed				
8 - 9.30	10	13.4	16	21.3
9.30 - 10	51	68.0	41	54.7
10	14	18.6	18	24.0

Table 5

Involvement of Respondents in Household Chores

Nature of Work	Morning				Evening				Both times			
	Male		Female		Male		Female		Male		Female	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Marketing	46	61.3	17	22.7	2	2.7	3	4.0	5	6.7	3	4.0
Fetching Water	19	25.3	32	42.7	1	1.3	5	6.7	3	4.0	6	8.0
Sibling care	5	6.7	14	18.7	-	-	1	1.3	-	-	3	4.0
Cleaning the House	9	12.0	49	65.3	-	-	4	5.3	1	1.3	9	12. 0
Washing Vessels	5	6.7	43	57.3	-	-	1	1.3	1	1.3	10	13.3
Cutting vegetables	6	6.7	21	28.0	-	-	3	4.0	1	1.3	10	13.3
Washing clothes	4	5.3	10	13.3	2	2.7	3	4.0	-	-	-	-
Cooking	-	-	8	10.7	-	-	3	4.0	-	-	2	2.7
None	16	21.3	2	2.7	-	-	-	-	-	-	-	-

22. CHANGING HEALTH BEHAVIOUR OF YOUTH

*Sumathy S.Rao**

I Introduction

In view of the enormous population of youth and for the effectiveness of the youth health campaign, youth between 10-25 years of age had been chosen as the Target Group of the International Year of the Youth - 1985 and this year in the ISHA Conference. The reason for the focus on this group is that motivation is high among young people and they can be educated effectively to in turn educate their own parents, the aged and children. Our outlook on youth must change. Every one should recognise that health of the youth is not luck or chance but must be worked for every day of one's life since frequently, disease strikes the youth due to the bad health habits. These habits are mostly inculcated in childhood or imitated from three sets of people - parents, friends and bad associates.

Youth problems are human problems and it is an issue of quality of life of the tomorrow's citizen. Therefore, health of the youth is one of the starting points of national welfare.

II A People's Movement for Changing Health Behaviour of the Youth

To me, it seems that the first requirement is to develop health consciousness amongst all sections of our people, not the least amongst those who are in responsible positions. Day-to-day reported activities on youth through print media has awakened psychiatrists, sociologists and other medical personnel to think in terms of applying innovative approaches in a systematic way, to spread the message of healthy living among youth.

Of particular concern is the growing tendency towards institutionalised violence which has grown on a world-wide scale. It is frequently a problem of semi-affluent youth seeking public recognition and apathy. According to Colin Yanham, Head of the Health Education Unit at the University of Technology, Sydney, Australia, there are some 30 million unprotected children on city

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streets faced with problems of parental rejection, drug abuse, sexual abuse, migration and more. Many of these problems result in feelings of helplessness and rebellious behaviour which may place their health and health of the society at risk in future. Apart from destitution,another major cause is the "generation" gap between the youth and their parents.

What we need is a massive people's movement which brings into focus the economic-socio-emotional factors in youth development, which some of us take for granted but which unfortunately the large majority of the youth, even if they are affluent, even though they have all the opportunities, do not always recognize as opportunities. Health programmes to change people's behaviour must form an integral part of our general national development. Our ancients right ly emphasised the close relationship between mind, emotions and the body. Each reacts with the other. It is therefore necessary, to create the right atmosphere as well as the physical conditions for good health of youth. The best treatment is prevention. Massive people's participation is needed to provide the social and emotional support to needy youth from high risk backgrounds such as broken families, alcoholic and other unstable family background. The support and care of large numbers of youth with such background will require massive voluntary effort by the better off sections of the community, in a spirit of neighbourly brotherhood.

III. Health Education and Promotion of Communation for Changing Health Behaviour of Youth

In 1989, the "Get Real Project" of Australia brought a very notable public alarm throughout the country. Drugs education and AIDS education was imparted through the popular music, lyrics and video stories. As a result, the drug users preferred to discard their used equipment in public places rather than run the risk of prosecution from disposing in rubbish. Surveys and analysis of drug users' behaviour resulted in an innovative response of administrators to the public health problem of discarded injection equipment,namely, initiation of an exchange programme by which the drug users could openly exchange used syringes and needles at Government approved outlets. This project received good participation, as the need for active participation of target populations in drug and AIDS control was well recognised. The

importance to youth and popularity of rock music and video is a well accepted principle in Australia. However, the innovation of the Get Real Project was that it utilized this principle to bring about a certain amount of awareness and effective communication and education. Therefore,as reported by HYGIE VOL. IX 1990 - Quarterly the success reaches out not only in the drugs area but also in the area of AIDS. This example illustrates the need for participation of the target groups in any health programme, particularly, health education.

According to Panlo Freire, if youth are participants in the process of determining their needs and priorities, there is an absolute change in their behaviour and health practices. Therefore, health education and promotion of health of youth should concern itself with the following:-

1. Providing knowledge on health to the youth;

2. Helping young people to determine their own health and life-style;

3. Helping them to understand their existence and their feelings, their attitudes and values and how they can maintain good human relationships;

4. Enabling the youth to understand the consequences of bad habits and teachi ng them to live in safe environment.

5. Helping them to understand the unhappy consequences of those who get into addictions and;

6. Helping them to help themselves in solving their own problems in order to recover from addictions.

IV Recommendations

1. There should be a close review of the growth needs of the youth by their parents.

2. Understanding, affection and correctional measures by the parents are important.

3. Close watch and avoidance of negligence of their youthful children is essential to facilitate human relationship and rehabilitation.

4. Efforts should be made by the parents, teacher and responsible persons in the family to identify youth problems and promoting health education programme.

5. A major programme should be developed to train the youth for leadership and youth development.

6. Counselling of youth often makes them adopt good health behavioural practices.

7. Personnel working in the social, psychiatric and health field should be alert to youth health problems and diagnose at an early stage, so that they can formulate strategies for youth development.

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23. HEALTH OF THE YOUTH IN INDIA

*Gladys Gunaseelan**

I Introduction

"The future of India lies in the hands of our youth", is a cliche repeated ly used by our leaders, politicians, educationists, and administrators. Yet, unfortunately the object of that statement, namely the youth of India, who today constitute nearly 21% of the total population of our country, are a neglected, exploited and confused lot facing several problems, unprecedented in terms of complexity and nature.

In the last few years especially, due to several socioeconomic and political factors there has been a trend of increasing youth health problems such as unemployment, suicide, alcoholism, drug abuse, accidents etc. Hence today, more than ever before, the issue of health-care for the youth assumes great importance.

II Rays of Hope - The Health Developments in Independent India

Today as we view the entire health scene in India we see several developments which encourage us and fill us with new hope. For instance, we have drastically reduced the infant-mortality rate; Our family planning programmes are slowly beginning to bear fruit as shown by the 1991 Census; To a great extent, leprosy has been conquered; The living standards of people has risen leading to a better understanding of sanitation and public hygiene; and epidemics such as cholera and small pox have been reasonably eradicated.

Despite these rays of hope, a great deal still remains to be done especially for our youth.

III Youth Problems the Causes

The kind of modern civilization, that has developed in India's urban areas, coupled with rapid technological and economic advances has led to a highly mehchanised, competitive and cold society. Soaring inflation, dramatic price-hikes of essential commo-

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dities, increased pollution, enormous mental stress and the disturbing social and political scenario, are some of the major factors that adversely affect health in India. These have led to the evils of unemployment, suicide, alcoholism, excessive drug abuse, sex-related offences and a general adverse effect on health.

IV The Government's Initiative

The Government of India evolved a National Health Policy which provides a comprehensive and integrated approach towards health and lays stress on the preventive promotive and rehabilitative aspects of health care. The goals of this policy are to be achieved through the elimination of poverty and ignorance, by raising the levels of nutrition. The National Health Policy, Keeping in view the emerging youth problems also emphasizes creation of awareness about health schemes and evils such as alcoholism and drug abuse. Further, stringent laws (e.g., against drug trafficking) have been implemented by the Government to help combat some of these evils.

V Recommendations

We need to develop and implement education programmes that will help enlighten the youth and enable them to overcome their health problems. In this cont-ext, the mass media, voluntary organisations and educational institutions shou-ld be roped in to help. Great care should also be given to rehabilitation of drug-victims, persons affected by AIDS, alcoholics etc. The careful provision of essential medicines,better hospitals and efficient health institutions, dedi-cated and motivated doctors, nurses and paramedical personnel are some of the vital inputs that should be developed.

But, what is more important in our mechanised world is to create a conductive and healthy climate of right values, good ethics, sound attitudes and moral principles that will equip our youth to face life better. To do this we have to pay great attention to the fundamental unit of society, namely-the family. The family has been called the giant shock absorber of society. "The place to which the bruised and battered individual returns after doing battle with the world". says Alvin Toffler. Hence care must be taken to strengthen Indian families by creating an atmosphere of security, trust and satisfaction. The Government must also create better avenues and climate for employment of the youth, thereby reducing their

frustration and insecurity. The concept of entrepreneurship is vital in this sense. It is always necessary to remember that health is more a condition of the mind rather than matter. By these strategies, we can assure the youth of India a better and healthier tomorrow.

As a noble soul once said "If our minds can conceive it and our hearts can believe it, we can most certainly achieve it". We need that kind of determination and strength to forge together a new India where every young man and woman will have better health, better resources and a better life. Into that haven of progress, let us march resolutely.

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24. ON PREVENTION OF BEHAVIOUR INJURIOUS TO HEALTH

*V.Natarajan**

I Introduction

"Cigarette smoking is injurious to Health" is the statutory warning printed on every pack of cigarettes. Similar such warnings are found displayed in liquor shops against alcoholic consumption and there is a complete ban on trafficking in narcotics.

Despite these statutory stipulations many people especially the youth are increasingly taking to smoking, alcohol and drugs and beocome addicts and end up tragically. Cases of such victims abound and has become a day-to-day occurance. Following three case studies would suffice to illustrate this.

II Case Studies of Youth

Case Study -1

"Raju", the son of a well to do and influential physician was a handsome youth. A dropout from an English medium school in the nearby city, he took to smoking and fun loving life. Naturally he came to be regarded as a local hero. Parents got him married to a young and attractive girl, with the hope that she would help change their son's life style. However, Raju continued his gay life, smoking heavily in style. despite his parent's concern and advice. Alas, he ended up as a lung cancer patient and did not live long despite surgical intervention and the best medical attention.

Case Study -2

"Prashanth", a college dropout took to his father's business and established himself soon as an astute businessman. Starting as a social drinker in his business dealings, he became an addict. Although otherwise of an athletic build and robust health, he started suffering from liver problem and attack of jaundice. Disregarding medical advice and warnings he continued to drink alcohol, and succumbed to it, while still in thirties, leaving behind aged parents and young wife.

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Case Study -3

"Aravind", a school dropout started working in his father's studio and deve-loped into a promising artist. With his assorted and wide clientele and contacts and enough money to spend, he took to drugs. The habit started affecting the family business and his family life. He had to be hospitalised for de-addiction and treatment at a great cost to the family and loss to its business.

III Prevention

In all the case studies it could be seen that all the victims, were talented school or college dropouts and developed the injurious habits early in youth, and became victims, because they did not heed to warnings and medical advice. It may be inferred that it is more difficult and less rewarding to treat those already afflicted with the addictions. Instead, it would be highly rewarding to approach likely victims early, educate them and persuade them to remain non-smokers, teetotallers and non-drug abusers.

This view has gained wide acceptance throughout the globe, and several advanced countries are committed and are taking concerted action on all fronts,to dissuade the practice of cigarette smoking, drug and alcohol abuse.

III.1 National and International Efforts

The WHO in response to the proven risks of smoking to the health of smokers as well as of non-smokers exposed to the passive smoking declared 31st May of every year to be celebrated as "The World No-Tobacco Day". Every year special themes are selected, such as,"The Female Smoker: at added risk" (1989), and "Child and Youth without Tobacco"(1990).

In our country, especially in Tamil Nadu, a couple of generations have grown without the taste of alcohol, thanks to the State policy of Prohibition, which however, now stands almost scrapped. The International Narcotics Control Strategy report issued by the U.S. State Department on August 21, 1990 points to significant progress in its efforts.

All these point to the increasing action and awareness,and also highlight the need for further intensified efforts by the Governments

of different States, and countries, in unilateral, bilateral and multilateral initiatives.

III.2 How do we Prevent the Development of Behaviour, Injurious to Health?

The topic for this paper has been chosen, mainly on the consideration that effort for prevention of smoking addiction is considered more effective then deaddiction of established smokers. Here it should not be construed that those who have already become addicts need not be attended to. The emphasis of anti-smoking campaigns is on considerably reducing the numbers of future addicts, though established smokers also need due attention.

In any programme against substance abuse (drugs, smoking and alcohol) it would be more rewarding to concentrate on prevention of smoking, because cigarette smoking is considered to be a gateway to drugs, i.e. young smokers are often induced to try other drugs. Therefore in this paper, attention will be focussed on developing a programme of persuading a non-smoker to remain a non-smoker.

III.3 Relevant Study Findings

1. Onset of smoking behaviour among school boys is in their early teens.

2. Majority of those who take to cigarette smoking do so due to peer influence.

3. There seems to exist an association between parents' (fathers') smoking behaviour and that of their children.

4. The peer group of smoking associates, includes school dropouts, comparitively older in age to the students.

5. Majority of the school dropouts had adjustment problems in their school.

6. Many of those who have adjustment problems in their scholastic performance were found to be back-benchers.

7. Frustrated scholastic aspirations appears to get reflected in learning atti tude and scholastic behaviour.

8. Interest shown by the class teachers appear to influence the students' readiness to expose themselves to antismoking messages.

9. Higher fear-arousing messages appear to affect the students attitude towards smoking bahaviour. Especially so with the non-smokers who affirm their resolve to remain non-smokers.

III.4 Anti-Smoking Programme for Youth

The above stated findings from several studies by the author and his associates point to the need for effective anti-smoking programme among students, for the success of which the following programme components may be considered.

1. Catch the students at the appropriate age, viz when they are in VI to VIII Std.

2. Anti-smoking education must sufficiently and vividly highlight the ill-effects of smoking, together with clearcut recommendations for non-smokers to remain non-smokers and for those who are learning to smoke, to cease smoking.

3. Influential teachers may be used to facilitate the reception of anti-smoking messages.

4. Non-smoker teacher models may be used as facilitators of anti-smoking campaign.

5. Regular monitoring of students adjustment problems as revealed by absenteeism, scholastic backwardness etc. may be done by the class teachers.

6. Students with adjustment problems be identified, and properly counselled, using teachers, and peers and parents.

7. School psychologists or trained professional health educators may be used for this purpose.

IV Conclusion

In conclusion, it may be said that, if the above stated activities are taken up as a routine and as part of School Health Programme both through the health staff and school psychologists where,

available, it is hoped that it would go a long way in inhibiting smoking behaviour among students, and may also prevent likely alcoholics and drug-addicts from the ranks of smokers.

To ensure better success, the anti-smoking campaign may be preceded with introduction of a lesson on ill-effects of cigarette smoking in an earlier class, say 3rd or 4th Standard, and succeeded by - 'World No-Tobacco Day'. and campaigns against alcohol and drug abuse, at high-school and college levels. Here, it may be suggested that since 31st May may happen to be a holiday in many schools and colleges, the Government of Tamil Nadu may issue instructions to College and School authorities to celebrate 'World No-Tobacco Day' in the month of June, immediately after reopening of summer holidays.

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25. THE ROLE OF INFORMATION EDUCATION AND COMMUNICATION (IEC) IN PRESERVATION AND DEVELOPMENT OF THE GIRL CHILD

*D.J.Samuel**

I Introduction

To preserve and develop the girl child in our Country the I.E.C activities should be geared up in the right direction. The girl child discrimination right from foetus to adolescence has to be tackled.

II IEC - to Improve the Girl Child's Social Image

The following I.E.C activities should be organized to improve the girl child's image in society:

a) interpersonal contact with women in the rural areas

b) group discussions and orientation to the women in all the villages and identifying the local culture;

c) orientation to the community leaders and impressing on them that girl child is not a liability but a resource;

d) by arranging public meetings and campaigns to focus the evil of dowry system;

e) film-shows, educational books to highlight the superior qualities of girl child like, and love for parents and sacrifice for the family;

f) slogans and posters and wall-paintings to crush the discrimination of female child must be displayed in rural areas to dispel the local culture or social pracitice.

III IEC- to Improve Girl Child's Health Opportunity

Various studies have shown that the female child suffers more from respiratory infections, protein caloric malnutrition, diarrhoeal diseases, riboflavin deficiency and other vitamin diseases besides neglect in respect of timely immunization.

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To alleviate these problems, Mass Media can effecitively be used:

a) the importance of breast feeding even to the female child, by filming stories specially written for that purpose.

b) the stress on environmental sanitation, diarrhoea and oral re-hydration can be taught by showing slides and film-strips in group meetings.

c) the dangers of six killer diseases and importance of immunization can be sh own by Video Cassettes.

d) the malnourishment to a female child can be impressed upon the women in rural areas by counteracting the local culture of not introducing solids to the baby at 4th month.

e) radios can broadcast the message regarding immunization and child rearing and utilization of existing facilities in primary health centres and urban heal th posts.

f) the Mass Media should propagate the importance of parental affection in infancy and early childhood.

IV IEC and the Problems of the Adolescent Girl

The specific problems of the adolescent girl which need the attention of professionals and administrators are as follows:

1. In rural areas, the girl works as helper to mother in collection of fuel, fodder and looking after young ones.

2. The girl child is sent as home-help to urban areas.

3. Less food is given to the female child when she needs increased nutritional requirement at the time of puberty.

4. Young girls are abused and lot of sex crimes are committed in their working places.

5. Girls are used as drug peddlers.

6. In big cities they are seen in redlight areas.

7. 25% of rape cases are girls under sixteen years.

8. Girls who are frequently put onto the occupations of bidimaking and other hazardous occupation, suffer from respiratory infections due to tobacco dust, eye problems because of the occupation of fine embroidery in dim light, and also from sexually transmitted diseases from sexual abuses.

The girl child enjoys less parental affection,less intellectual stimulation and fewer opportunities to learn, travel and develop her personality. She faces every odd in her struggle for survival and caught in cultural practices and prejudices that strips her of her individuality.

In some cases the mental make-up never gets matured and remains unhappy as well as apathetic towards her own life. As a result, when she becomes a wife or mother, she cannot cope and this can result in suicide and broken marriages.

The mass media can play a tremendous role in changing the situation of the adolescent female child by:

a) showing the real setup of our society and the plight of adolescent girls in rural and urban areas.

b) screening historical plays of great Indian queens and women

c) broadcasting messages from popular leaders regarding the importance of girl child.

d) properly reporting the incidents involving girl child abuse.

e) screening dramas that will stimulate the thinking of people

f) holding women's seminars in urban and rural areas to create awareness of the rights of the girl child to have adequate nutrition and thereby become a healthy mother who can deliver a healthy child.

g) campaigning in every town and city to deliver the girl child from her misery.

h) highlighting the lacunae in social legislation and to bring about social pressure for changes in the laws.

i) informing the public about existing facilities for vocational studies.

j) introducing education classes for school dropouts.

k) writing catchy slogans and posters in rural and urban areas to focus on the merits of Girl Child.

The message of the great poet Rabindranath Tagore should not be forgotten but emphasised and accepted by our Nation.

"Women is the moulder and builder of a Nation's destiny. Though she is delicate and soft as lily, she has a heart far braver and stronger than a man. She is the supreme inspiration for man's onward march".

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26. HEALTH OF THE YOUTH AND THE FEMALE CHILD (ABSTRACT)

*Padmini Sivasubramaniam**

This paper dealt with the sociocultural disadvantages of the female child. The national statistics on the general child situation were presented. Against this background, the additional disadvantages of the female child were also discussed, specially, the gross violation of the UN Declaration of the Rights of the Child, in respect of girl children. Some of the problems of youth, the fem ale adolescent and their sociocultural context were also discussed.

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- ISHA has organized annualconferences on "Primary Health Care for All By 2000 A.D." (1980); "Role of Hospitals in Health Care" (1981); Health Manpower for Primary Health Care" (1982); "Health Administrator in India" (1983); "Financing of Health Services in India" (1984); "On Growing Needs of Urban Health Management" (1985); "Cost Reduction in Hospital and Health Care" (1986); "Health of the High Risk Groups-Mothers, Children and Elderly" (1987) and "Health of Women and Children for Development" (1988).

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- Construction for the international headquarters of ISHA would begin soon.